UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

Civil Action No: _____

Linda Ditomasso,
Plaintiff

vs.

05-40057 FDS

Philip Services Corporation, PSC Group Life Plan and Continental Assurance Company,
Defendants

PLAINTIFF'S COMPLAINT

I - NATURE OF THE ACTION

Pursuant to 29 U.S.C. § 1132(a)(1)(B), the Plaintiff, Linda Ditomasso, files this Complaint against the Defendants seeking judicial review of the denial of her claim for benefits under the Supplemental Life portion of her deceased husband's insurance policy issued by Continental Assurance Company.

II - PARTIES

1. The Plaintiff, Linda Ditomasso ("Mrs. Ditomasso"), is an individual with a usual place of residence in Charlton, Worcester County, Massachusetts.

2. The Defendant, Continental Assurance Company ("CNA") is, upon information and belief, a corporation with a usual place of business at CNA Plaza, Chicago, Illinois.

3. The Defendant, Philip Services Corporation ("PSC") is, upon information and belief, a corporation with a usual place of business at 31 Waldron Way, Portland, ME 04103.

4. The Defendant, PSC Group Life Plan ("PSC Plan"), is a plan of benefits for PSC employees (the "Plan").

5. The Defendant, CNA, issued a Group Life Insurance Policy No: SR-83120541 (hereinafter "the Policy") to employees of PSC who enroll in the Plan. Exhibit #1.

RECEIPT # 404542
AMOUNT $ 250.00
SUMMONS ISSUED 3
LOCAL RULE 4.1 ✓
WAIVER FORM ✓
MCF ISSUED ✓
BY DPTY. CLK KH
DATE 3-29-05

1

III - JURISDICTION AND VENUE

6. Jurisdiction of this Court is based upon 29 U.S.C. §§ 1132(e)(1) and (f) which vests in the districts courts jurisdiction to hear civil matters brought to recover benefits due under the terms of an employee benefit plan.

7. CNA provides participants in the Commonwealth of Massachusetts Group Life Insurance Plans with Supplemental Life Insurance subject to the terms and conditions of the Plan.

8. Under the Employee Retirement Income Security Act of 1974, as amended (hereinafter "ERISA") (29 U.S.C. Section 1001 et seq.), the Plan at issue in this litigation must contain provisions for an administrative or internal appeal from a denial of benefits.

9. The Plaintiff has exhausted her administrative remedies in this claim and this matter is, therefore, properly before this Court for judicial review of the denial of her benefits.

10. Venue is proper in this district pursuant to 29 U.S.C. § 1132 (e)(2) which allows an action under Title I of ERISA to be brought in the district where the plan is administered, where the breach took place or where a defendant resides or may be found and process may be served in any other district where a defendant resides or may be found.

IV – GENERAL ALLEGATIONS

11. Prior to his death and during all relevant times, Ronald Ditomasso ("Mr. Ditomasso") was employed at PSC with a varying hourly pay that did not, during the relevant time period, exceed $50,000 per year. Mr. Ditomasso was a member of the Plan.

12. By letter dated August 15, 2000, Cynthia Demers, Benefits Administrator for PSC, advised Mr. Ditomasso that he was eligible to enroll in the Supplemental Life Plan. Exhibit #2.

13. Mr. Ditomasso enrolled in the Plan on December 10, 2001 with an effective date of January 1, 2002. At that time, Mr. Ditomasso elected Supplemental Life Insurance of one times his base salary. Exhibit #3.

14. Mrs. Ditomasso married Mr. Ditomasso on February 1, 2002.

15. On February 19, 2002, Mr. Ditomasso renewed his requested coverage due to a family status change, namely, his marriage to Mrs. Ditomasso. The effective date of coverage was February 1, 2002. Mr. Ditomasso again elected Supplemental Life insurance of one times his base salary. He also elected Spousal Life coverage of $10,000. Exhibit #4.

16. PSC, CNA and/or PSC Plan received the above coverage request on February 25, 2002, and, upon information and belief, approved the insurance on February 26, 2002. Exhibit #4.

17. By at least April 26, 2002, premiums for the Supplemental Life Insurance were deducted from Mr. Ditomasso's paycheck.

18. On November 13, 2002, Mr. Ditomasso renewed his Life, Supplemental Life and Spousal Life coverage with an effective date of January 1, 2003. Exhibit #5.

19. PSC, CNA and/or PSC Plan received the above renewal on November 19, 2002 and approved the request on December 4, 2002. Exhibit #5.

20. On December 26, 2003, Mr. Ditomasso died. Exhibit #6.

21. Mrs. Ditomasso is the beneficiary of her husband's Supplemental Life Insurance.

22. Every week, beginning at least April 26, 2002 and ending with his death, PSC, CNA and/or PSC Plan accepted Mr. Ditomasso's premium payments for Supplemental Life Insurance coverage.

23. At CNA's request, Mrs. Ditomasso signed a Proof of Death Form which was prepared by CNA. The form confirmed in writing that Mr. Ditomasso was entitled to $35,000 in Supplemental Life Insurance coverage. Exhibit #7.

24. The form, provided by CNA, also confirmed that Mr. Ditomasso's insurance was in-force at the time of Mr. Ditomasso's death and effective as of January 01, 2001. Exhibit #7.

25. PSC, CNA and/or PSC Plan has refused to pay Mrs. Ditomasso Supplemental Life Insurance benefits concluding that Mr. Ditomasso was a "Late Enrollee" and, as such, he was required to provide CNA with Evidence of Insurability to be eligible for Supplemental Life Insurance. Exhibit #8.

26. PSC, CNA and/or PSC Plan has not reimbursed Mrs. Ditomasso for the two years of Supplemental Life Insurance premiums received.

27. Mr. Ditomasso was not a late enrollee.

28. With regard to eligibility for Supplemental Life Insurance, CNA's Group Life Insurance policy for PSC states, in pertinent part:

Supplemental Life Guaranteed Issue Amount:

Base Earnings	**Guarantee Issue Amount**	**Evidence of Insurability**
$50,000 or less	5 times earnings	N/A

Exhibit #1 at 4.

29. The November 13, 2002, enrollment form states: "EOI required for amounts > $250,000." Exhibit #5.

30. The relevant enrollment forms state, "Supplemental Life Insurance *May* Be Subject to Evidence of Insurability." [Emphasis added.] Exhibits #3, #4 and #5.

31. The Group Policy states with respect to what is required to become insured:

> To become insured You must:
>
> 1) be an Eligible person;
> 2) complete the Waiting Period, if any;
> 3) complete a group insurance enrollment form acceptable to Us;
> 4) provide *any* required Proof of Insurability; and
> 5) agree to pay any required premium.

Exhibit #1 at 6.

32. The Group Policy further provides:

> What is meant by providing Proof of Insurability?
> Providing Proof of Insurability means that You must fully complete Our Proof of Insurability application, and at Your expense:
>
> 1) undergo a physical examination and/or submit to the collection and testing of Your blood or urine specimens, *if required by Us*; and
> 2) provide any additional information that *We may* reasonably require to evaluate Your request for coverage.

Exhibit #1 at 8.

33. For almost two years, the Defendants accepted premium payments from Mr. Ditomasso for Supplemental Life coverage. At no time did the Defendants require, verbally or in writing, additional documentation, a physical examination, or the collection or testing of Mr. Ditomasso's blood or urine specimens as a condition precedent to Mr. Ditomasso's eligibility for coverage.

34. With respect to Evidence of Insurability requirements, the relevant enrollment forms, Exhibits #3, #4 and #5, explain that by signing each applicant "authorize[s] any physician, other health professional, all hospitals and other health care institutions to provide Health Care information concerning health care advise, treatment or supplies." Mr. Ditomasso signed those forms.

35. The Group Life Insurance policy excepts the Proof of Insurability requirement under the following circumstance:

> When is the proof of insurability requirement waived for late enrollees? If You are a late enrollee, We will not require Proof of Insurability up to the Guaranteed Issue Amounts if You make request for coverage due to a Family Status Change.

Marriage qualifies as a Family Status Change under the Policy. Exhibit #1 at 8.

COUNT I - CLAIM FOR BENEFITS/BREACH OF CONTRACT (CONTINENTAL ASSURANCE COMPANY)

36. The Plaintiff, Mrs. Ditomasso, realleges and incorporates by reference the allegations set forth in paragraphs 1-35 of this Complaint.

37. The decision to deny Mrs. Ditomasso Supplemental Life Insurance proceeds is arbitrary and capricious, wholly unreasonable and against the weight of the evidence.

38. The Defendants misapplied the group policy as it relates to late enrollees and proof of insurability and deprived Mrs. Ditomasso of benefits to which she is entitled under the terms of the Plan.

39. Without justification and in material and substantial breach of the contract, the Defendants refused to pay Mrs. Ditomasso the proceeds of Mr. Ditomasso's Supplemental Life Insurance upon his death.

40. Mr. Ditomasso paid the premiums for Supplemental Life Insurance for almost two years and Defendants accepted and cashed those payments.

41. The Defendants waived any requirement that Mr. Ditomasso provide Evidence of Insurability and is estopped from claiming same.

42. For the benefit of his wife, Mr. Ditomasso relied on Defendants' actions and representations to his and her detriment.

43. The Defendants have not reimbursed Mrs. Ditomasso for the premium payments it has received for Supplemental Life Insurance. The Defendants have been unjustly enriched.

44. The Defendants are estopped from denying benefits for which it has received and accepted payment.

COUNT II - CLAIM FOR BENEFITS/BREACH OF CONTRACT (PHILLIP SERVICES CORPORATION)

45. The Plaintiff, Mrs. Ditomasso, realleges and incorporates by reference the allegations set forth in paragraphs 1- 35 of this Complaint.

46. The decision to deny Mrs. Ditomasso Supplemental Life Insurance proceeds is arbitrary and capricious, wholly unreasonable and against the weight of the evidence.

47. The Defendants misapplied the group policy as it relates to late enrollees and proof of insurability and deprived Mrs. Ditomasso of benefits to which she is entitled under the terms of the Plan.

48. Without justification and in material and substantial breach of the contract, the Defendants refused to pay Mrs. Ditomasso the proceeds of Mr. Ditomasso's Supplemental Life Insurance upon his death.

49. Mr. Ditomasso paid the premiums for Supplemental Life Insurance for almost two years and Defendants accepted and cashed those payments.

50. The Defendants waived any requirement that Mr. Ditomasso provide Evidence of Insurability and are estopped from claiming same.

51. For the benefit of his wife, Mr. Ditomasso relied on Defendants' actions and representations to his and her detriment.

52. The Defendants have not reimbursed Mrs. Ditomasso for the premium payments it has received for Supplemental Life Insurance. The Defendants have been unjustly enriched.

53. The Defendants are estopped from denying benefits for which it has received and accepted payment.

COUNT III - CLAIM FOR BENEFITS/BREACH OF CONTRACT (PSC GROUP LIFE PLAN)

54. The Plaintiff, Mrs. Ditomasso, realleges and incorporates by reference the allegations set forth in paragraphs 1- 35 of this Complaint.

55. The decision to deny Mrs. Ditomasso Supplemental Life Insurance proceeds is arbitrary and capricious, wholly unreasonable and against the weight of the evidence.

56. The Defendants misapplied the group policy as it relates to late enrollees and proof of insurability and deprived Mrs. Ditomasso of benefits to which she is entitled under the terms of the Plan.

57. Without justification and in material and substantial breach of the contract, the Defendants refused to pay Mrs. Ditomasso the proceeds of Mr. Ditomasso's Supplemental Life Insurance upon his death.

58. Mr. Ditomasso paid the premiums for Supplemental Life Insurance for almost two years and Defendants accepted and cashed those payments.

59. The Defendants waived any requirement that Mr. Ditomasso provide Evidence of Insurability and are estopped from claiming same.

60. For the benefit of his wife, Mr. Ditomasso relied on Defendants' actions and representations to his and her detriment.

61. The Defendants has not reimbursed Mrs. Ditomasso for the premium payments it has received for Supplemental Life Insurance. The Defendants have been unjustly enriched.

62. The Defendants are estopped from denying benefits for which it has received and accepted payment.

Wherefore, the Plaintiff, Linda Ditomasso, requests that this Court grant the following relief:

1. That this Court order, declare and adjudge that under the terms of the Policy, Mrs. Ditomasso is entitled to the proceeds of the Supplemental Life Insurance;

2. That after making such a determination, the Court order the Defendants to provide all Supplemental Life proceeds to which Mrs. Ditomasso is entitled under the terms and conditions of the Policy, plus interest and costs;

3. That the Court award Mrs. Ditomasso her attorney fees pursuant to 29 USC § 1132(g) as well as interest and costs; and

4. That the Court award Mrs. Ditomasso such further necessary or proper relief as it deems just and equitable.

Linda Ditomasso
by her attorney,

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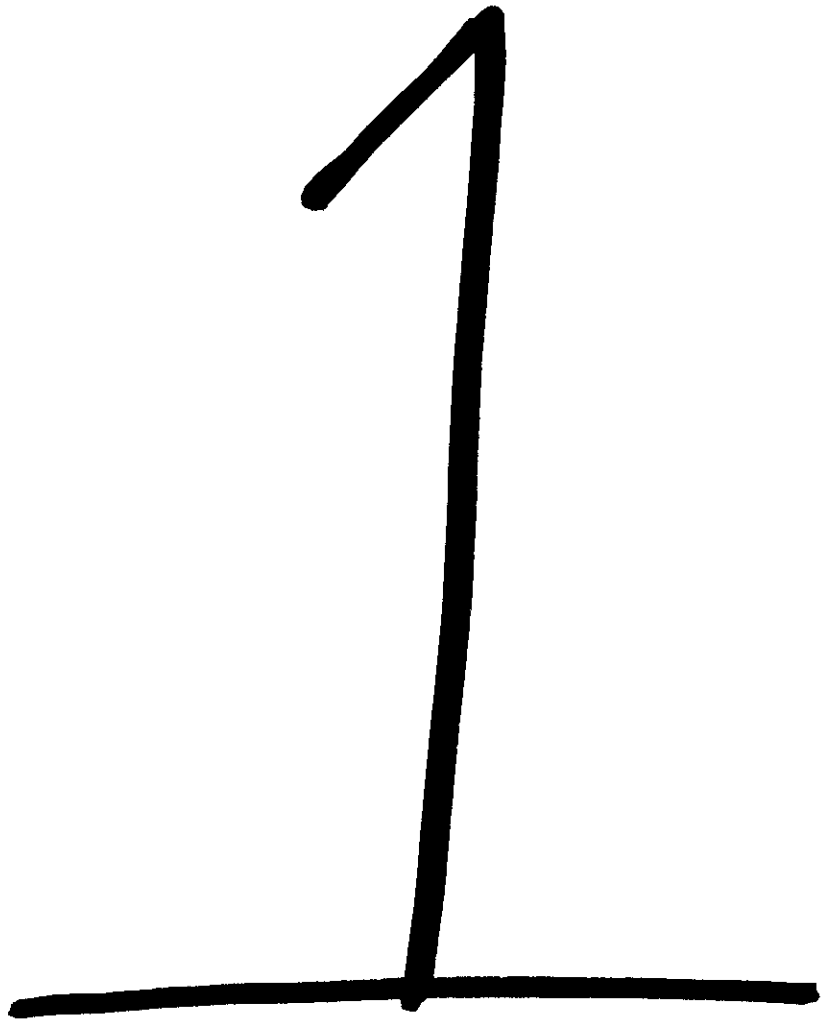

Group Life Insurance for

INSURANCE IN TOUCH WITH BUSINESS

Continental Assurance Company

CNA Plaza
Chicago, Illinois 60685

A Stock Company

Having issued Group Policy No. SR-83120541

to

PSC

(herein called the Holder)

CERTIFICATE OF INSURANCE

Continental Assurance Company hereby certifies that You are insured under the Policy provided that You qualify under the Eligibility and Enrollment provision, become insured and remain insured in accordance with the terms of the Policy. Your insurance is subject to all of the definitions, limitations, and conditions of the Policy.

This certificate is not the entire contract of insurance. It is a part of the Policy and is evidence of Your insurance. It takes effect at 12:01 A.M. Standard Time on the date determined by the Effective Dates provision of the Policy. The Policy can be amended by mutual consent between the Holder and Us.

The Policy is in the Holder's possession and may be inspected by You at any time during normal business hours at the Holder's office.

This certificate replaces any other certificate previously issued to You under the Policy. This certificate is not valid unless the Schedule of Benefits is attached.

EXAMINING YOUR CERTIFICATE

It is important that You understand the coverage described in this certificate. You should read it carefully. If You have any questions, You should contact the Holder. You may also write to Us and We will attempt to assist You.
TLC-1AA

Signed for the Continental Assurance Company

Bernard L. Hengesbaugh

Chairman of the Board

Group Term Life Insurance Certificate
Conversion Privilege
Waiver of Premium Disability Benefit
Renewable with the Consent of the Company
Non-Participating

SBGTL-C

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SCHEDULE OF BENEFITS

Effective as of: January 1, 2001

Holder: PSC

Policy Number: SR-83120541

Policy Effective Date: January 1, 2001

Eligible Class: All individuals in the following class are eligible for insurance:

Class 1

All active, full-time regular, salaried non-represented employees of the Holder working in the United States of America.

Class 2

All active, full-time regular hourly non-represented employees of the Holder working in the United States of America.

Class 3

All casual, hourly, non-represented employees of the Holder, insured under the prior policy on the day prior to the effective date of this policy working in the United States of America.

"Full-time" means Actively Working an average of at least 30 hours per week for the Holder. All part-time, temporary, seasonal, preferred project, casual, or retired employees of the Holder are not eligible, except for members of Class 3.

Waiting Period: (Class 1)

- If You are in an Eligible Class on or before the Policy Effective Date – 1st of the month coincident with or next following the Your date of hire.
- If You are in an Eligible Class after the Policy Effective Date – 1st of the month coincident with or next following the Your date of hire.

Waiting Period: (Class 2)

- If You are in an Eligible Class on or before the Policy Effective Date – 1st of the month coincident with or next following 90 days.
- If You enter an Eligible Class after the Policy Effective Date – 1st of the month coincident with or next following 90 days.

Waiting Period: (Class 3)

- Not Applicable

Your Waiting Period will be waived if You were insured under the Prior Policy on the day prior to the effective date of the Policy.

Waiver of Premium Elimination Period: 9 Months

YOUR BASIC AND SUPPLEMENTAL BENEFITS

Amount of Basic Life Insurance:

Class I: 1 times Your Basic Annual Salary, rounded to the Next Highest $1,000 if not already a multiple of $1,000. The amount of Your Basic Life Insurance cannot exceed a maximum of $500,000.

Amount of Basic Life Insurance: Class 2 & 3: 1 times Your Basic Annual Salary, rounded to the Next Highest $1,000 if not already a multiple of $1,000. The amount of Your Basic Life Insurance cannot exceed a maximum of $40,000.

Amount of Supplemental Life Insurance: 1, 2, 3, 4, 5 times Your Basic Annual Salary, rounded to the Next Highest $1,000 if not already a multiple of $1,000. The amount of Your Supplemental Life insurance cannot exceed a maximum of $500,000.

Basic Life Guaranteed Issue Amount: $500,000

Supplemental Life Guaranteed Issue Amount:

Base Earnings	Guarantee Issue Amount	Evidence of Insurability Required
$50,000 or less	5 times earnings	N/A
$50,001 - $62,500	4 times earnings	For 5 times earnings
$62,501 - $83,333	3 times earnings	For 4 or 5 times earnings
$83,334 - $125,000	2 times earnings	For 3, 4, or 5 times earnings
$125,001 - $250,000	1 times earnings	For 2, 3, 4, or 5 times earnings
$250,001 or greater	N/A	For any amounts of Supplemental Insurance

Minimum Amount of Life Insurance: $10,000

Maximum Amount of Life Insurance: Your amount of Basic and Supplemental Life Insurance may not exceed a combined maximum amount of $1,000,000.

Basic Annual Salary means the base salary paid to You each year by the Holder. It does not include commissions, bonuses, overtime pay or any other compensation.

Benefit Reduction Due to Age: The original benefit amounts in force prior to age 70 will reduce to 65% at age 70, at age 75 will reduce to 45%, and at age 80 to 30%.

YOUR SUPPLEMENTAL DEPENDENT BENEFITS

Eligible Dependents	Amount of Dependent Life Insurance
Your lawful spouse	You may request insurance on the life of Your Dependent spouse in increments of $10,000, not to exceed a maximum of $100,000.
Your unmarried Child from:	
14 Days to 6 Months	$500
6 Months to 19 Years old	You may request insurance on the life of your Dependent Child in increments of $2,000 not to exceed a maximum of $10,000.

Child coverage may be extended for Your unmarried Child up to age 25, if Your Child is:

1) attending an accredited school full-time; and
2) financially dependent upon You for support.

Guaranteed Issue Amount for Dependent Life Insurance: $20,000

Maximum Amount of Dependent Life Insurance: The amount of Dependent Life Insurance for any one Dependent may not exceed a maximum of $100,000.

Benefit Reduction Due to Age: The Dependent Life Insurance benefit for Your Spouse in force prior to age 70 will reduce to 65% at age 70, will reduce to 45% at age 75, and to 30% at age 80.

ADDITIONAL BENEFITS

The following additional benefits are included:

- Accelerated Benefit
- Portability
- Conversion
- Waiver of Premium Disability Benefit

IMPORTANT: THIS SCHEDULE OF BENEFITS IS A PART OF YOUR CERTIFICATE OF INSURANCE. IT IS EVIDENCE OF YOUR COVERAGE AND SHOULD BE ATTACHED TO YOUR CERTIFICATE OF INSURANCE. IT REPLACES AND CANCELS ALL OTHER SCHEDULE OF BENEFITS, IF ANY, ISSUED TO YOU UNDER THE POLICY.

TLCS

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?

All persons in an Eligible Class shown in the Schedule are considered Eligible Persons.
TLC-2AA

When are You eligible to enroll?

When You become an Eligible Person, You may enroll for coverage immediately if there is no Waiting Period. If a Waiting Period applies, You may enroll on the first of the following dates:

1) the Policy Effective Date, if You have completed the Waiting Period on or before that date; or
2) the day after You complete the Waiting Period, if such date falls after the Policy Effective Date.

TLC-3AA

What happens during Your initial enrollment period?

When You are first eligible to enroll, You will automatically be enrolled for Non-Contributory Life Insurance and any other Non-Contributory coverage. You may refuse such coverage. The refusal must be in writing on a form provided by Us. If You later apply for coverage, You will be considered a Late Enrollee.

You may also elect to enroll for any coverage under the Contributory plan of insurance. If You choose not to enroll for the Contributory coverage during Your initial enrollment period, and later apply, You will be considered a Late Enrollee.
TLC-4AA

What is required to become insured?

To become insured You must:

1) be an Eligible Person;
2) complete the Waiting Period, if any;
3) complete a group insurance enrollment form acceptable to Us;
4) provide any required Proof of Insurability; and
5) agree to pay any required premium.

TLC-5AA

EFFECTIVE DATES

When does Your insurance start?

If You enroll within 31 days after first becoming eligible to enroll for coverage, Your insurance up to the Guaranteed Issue Amount will take effect on the later of:

1) the date You enroll; or
2) the date You satisfy the Waiting Period, if any.

You must apply for any amounts over the Guaranteed Issue Amount. Such coverage will take effect on the first of the month that falls on or next follows the date We approve Your Proof of Insurability.

No coverage will go into effect until You have satisfied the Waiting Period. If You are a Late Enrollee, Your insurance will take effect on the first of the month that falls on or next follows the date We approve Your Proof of Insurability.
TLC-8AA

When will insurance become effective if a disabling condition causes You to be absent from work on Your Effective Date?

If, because of injury or sickness, You are not Actively at Work on the date the insurance would otherwise become effective, it will take effect on the day after return to Active Work for a period of 1 day.
TLC-9AA

CHANGES IN AMOUNTS OF INSURANCE

When does Your coverage amount change if there is a change in Your class or the plan?

If there is an increase in Your coverage amount due to a change in Your class or the plan, Your new coverage amount will become effective as follows:

1) For amounts less than the Guaranteed Issue Amount: Your effective date will be the date You are first eligible for the increase in benefits;

2) For amounts above the Guaranteed Issue Amount: Your effective date will be on the first of the month that falls on or next follows the date Your Proof of Insurability is approved by Us.

If You are not Actively Working on the date the insurance would otherwise take effect, it will take effect on the day after You return to Active Work for a period of 1 day.

Any type of decrease in coverage will become effective on the date of the change whether or not You are Actively at Work.
TLC-10AA

When does Your coverage amount change if there is a change in Your salary?

An increase in Your coverage amount due to a change in salary will become effective on the later of:

1) the date of change, if Proof of Insurability is not required; or
2) the first of the month that falls on or next follows the date We approve Your Proof of Insurability, if required.

If You are not Actively Working on the date the insurance would otherwise take effect, it will take effect on the first day after You return to Active Work for a period of 1 day.

Any type of decrease in coverage will become effective on the date of the change whether or not You are Actively at Work.
TLC-11AA

What if You request an increase or decrease in coverage?

You must apply in writing for any increase in Your coverage amount. Such increase will take effect on:

1) the date of Your request, if Proof of Insurability is not required; or

2) the first of the month that falls on or next follows the date We approve Your Proof of Insurability, if required.

If You are not Actively Working on the day the increase would otherwise have taken effect, the effective date of such increase will be delayed until the first day after You return to Active Work for a period of 1 day.

If You make a request for a decrease in coverage, it will become effective on the date of the change, whether or not You are Actively at Work.
TLC-12AA

When does Your coverage amount change if there is a reduction due to age?

If You have attained one of the benefit reduction ages stated in the Schedule, Your coverage amount will be reduced. Any reduction will be in accordance with the reduction percentage shown for Your age. The reduction for each age will take place as follows:

1) immediately, if You have already attained the reduction age at the time Your insurance goes into effect; or
2) on the date You attain the reduction age, if this occurs after Your insurance goes into effect.
TLC-13AA

PROOF OF INSURABILITY

What is meant by providing Proof of Insurability?

Providing Proof of Insurability means that You must fully complete Our Proof of Insurability application, and at Your expense:

1) undergo a physical examination and/or submit to the collection and testing of Your blood or urine specimens, if required by Us; and

2) provide any additional information that We may reasonably require to evaluate Your request for coverage.

TLC-14AA

The above expenses, if any, will be waived where required by law.

TLC-15BA

When is Proof of Insurability required?

Proof of Insurability must be provided if:

1) You are a Late Enrollee;

2) Your amount of Life Insurance exceeds the Guaranteed Issue Amount stated in the Schedule, if applicable;

3) You request an increase in Your amount of Life Insurance, if applicable;

4) a change in Your salary increases Your Life Insurance by more than one times Your annual salary or $50,000, whichever is less; or

5) Your coverage is reinstated and Proof of Insurability is required by Us.

6) You request to continue Your Life Insurance under the Pathway Portability provision and Proof of Insurability is required.

Proof of Insurability will not be required for any amount of insurance that We agree to carry over from the Prior Policy. Such agreement must be in writing.

TLC-16AA

When is the Proof of Insurability requirement waived for Late Enrollees?

If You are a Late Enrollee, We will not require Proof of Insurability up to the Guaranteed Issue Amounts if You make request for coverage due to a Family Status Change. To qualify, You must enroll for coverage and provide proof of Your Family Status Change within 31 days after the date of change.

The qualifying Family Status Changes acceptable to Us, and the Acceptable Proof required for each change are listed below.

FAMILY STATUS CHANGES	
Family Status Changes	**Acceptable Proof**
Birth of a Child	Birth Certificate
Adoption of a Child	Adoption Papers
Death of a Spouse	Death Certificate
Divorce	Divorce Decree
Marriage	Marriage Certificate
Spouse's Loss of Job	Separation Papers from Spouse's Employer

TLC-17AA

LIFE INSURANCE BENEFIT

What is Your Death Benefit?

Your Death Benefit is the amount of Your Life Insurance shown in the Schedule, subject to any reduction under the Policy. Death Benefits will be paid to Your Beneficiary upon Our receipt of due proof of Your death.
TLC-18AA

What happens if the cause of death is due to suicide? *(Applicable to Contributory coverage only)*

If You die as the result of suicide or any attempt at suicide, while sane or insane, within 2 years of Your effective date of coverage, Our liability will be limited to a refund of the premiums actually paid for Your Life Insurance.

With respect to any increase in the amount of insurance, We will consider the 2-year period to begin as of the effective date of such increase.

Our return of premiums will be in lieu of any Death Benefit that would have been payable.
TLC-19AA

What is needed before We can pay the Death Benefit?

Claims must be filed on Our forms. A claim form may be obtained from the Holder or Us.

The following are required before the Death Benefit can be paid:

1) a fully completed claim form;
2) a certified copy of the deceased's death certificate; and
3) any other documents that We may reasonably require to establish due proof of death.

After the required forms are received and approved by Us, the Death Benefit will be paid.
TLC-20AA

CONVERSION PRIVILEGE

Under what conditions can Your Life Insurance coverage be converted to another plan of insurance?

You may convert Your Life Insurance coverage to an individual policy if:

1) Your coverage terminates or reduces, while the Policy is in force, and one of the following applies:
   a) Your employment ends;
   b) You are no longer in an Eligible Class;
   c) You reach a specified age;
   d) You change from one Eligible Class to another providing a lower benefit; or
   e) You retire.

   The amount of life insurance may not exceed the amount terminated under the Policy. Such amount will be reduced by any amount of group life insurance for which You are or become eligible within 31 days of termination.

2) You have been continuously insured under the Policy for at least 5 years and Your coverage terminates because the Policy terminates, or the Policy is amended so as to terminate insurance for Your class.

   The amount of insurance for this insurance policy will be the lesser of:

   a) $10,000; or

   b) the amount for which You were insured under the Policy, reduced by any amount for which You are or become eligible under any group life insurance policy within 31 days of termination.

TLC-28AA

How do You convert coverage?

To convert Your Life Insurance coverage You must:

1) Make written application to Us within 31 days after Your insurance ends; and
2) Include the first premium payment with Your application. The premium will be based on the rates filed by Us for the policy to be issued. It will also be based on Your attained age and class of risk, and the amount of insurance.

When We receive Your written application and first premium payment, We will issue to You an individual life insurance policy. The issuance of the policy will be subject to the following conditions:

1) no Proof of Insurability is needed;
2) the individual policy will be on one of the forms, except term insurance, that We issue for conversion coverage; and
3) the individual policy may not contain disability, accidental death and dismemberment or other supplementary benefits.

Any individual policy issued under this Conversion Privilege will be in lieu of all other benefits under the Policy.
TLC-29AA

What if You die during the conversion election period?

If You die within the 31-day conversion period, We will pay, upon receipt of proof of Your death, the amount of Your Life Insurance that You were entitled to convert. The claim will be paid under the Group Policy, even if the application or payment of the first premium for the individual policy has not been made.
TLC-30AA

What happens if You convert Your coverage and later become eligible again for coverage under the Policy?

If You have converted Your coverage to an individual policy, You will not have to surrender Your conversion policy if You become insured again under the Policy. If You once again become ineligible for coverage under the Policy, You will not be able to convert Your coverage a second time if Your original individual conversion policy is still in force.
TLC-31AA

What are the notice requirements for conversion?

The Holder will notify You in writing of Your rights to convert Your coverage under the Policy. If the notice is not received within 31 days after Your insurance terminates, the application period for conversion may be extended for an additional 60 days. In no event, will the application period exceed 91 days following the date of Your termination.
TLC-32AA

WHAT ADDITIONAL BENEFITS ARE AVAILABLE UNDER EMPLOYEE INSURANCE?

WAIVER OF PREMIUM DISABILITY BENEFIT

What is the Waiver of Premium Benefit and to what coverages does it apply?

This provision provides for the continuation of Your Life Insurance without premium charge during the continuance of Your Total Disability. If You qualify for this benefit, Your Dependent Life Insurance will also be extended without premium charge.

Accidental Death and Dismemberment Benefits (if any), and any other additional benefits offered under the Policy will not be continued under this provision.

What is the amount of Life Insurance kept in force under this provision?

The amount of Life Insurance continued under this provision will be the amount of Life Insurance and Dependent Life Insurance in force on the last day of Your active employment immediately preceding the date Your Total Disability begins.

All insurance continued under this provision will be subject to the benefit reductions stated in the Policy.

Are there any exclusions under this benefit?

We will not waive premiums if Your Total Disability results from intentionally self-inflicted injuries, while sane or insane.

What conditions must be satisfied before You may qualify for Waiver of Premium?

To qualify for this benefit:

1) You must become Totally Disabled while You are insured under the Policy, and before You reach age 60;
2) You must remain Totally Disabled during the Elimination Period; and
3) We must receive written notice of claim from You, or a person acting for You:
    a) during Your lifetime;
    b) as soon as reasonably possible;
    c) during the continuance of Your Total Disability; and
    d) before Your insurance ends.

    We will not refund more than 12 months premium, if written notice is received more than 12 months from the date Your Total Disability started.

What items must be supplied to establish proof of disability?

We must receive due proof of Your Total Disability before We will waive Your premium. Such proof must be sent to Us as soon as reasonably possible. Failure to provide proof of disability may delay, suspend or terminate Your benefits. The items listed below are supplied at Your expense and must be a part of Your proof of loss.

1) Our disability claim form. You may obtain Our disability claim form from Us or the Holder. This form must be fully completed and signed by You, Your employer, and Your Doctor.
2) Proof that You are receiving Appropriate and Regular Care for Your condition from a Doctor whose specialty or expertise is the most appropriate for the treatment Your Total Disability according to Generally Accepted Medical Practice.
3) Objective medical findings which support Your Total Disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine for Your disability.
4) Documents detailing the extent of Your Total Disability, including any restrictions or limitations.

What happens if You die within 12 months before giving Us the first proof?

If You become Totally Disabled while insured under the Policy, and die within one year of the date Your Total Disability started without giving Us the first proof, Your Death Benefit will be paid to Your Beneficiary if:

1) We receive written proof of Your continuous Total Disability from the date Your Total Disability started to Your date of death;
2) We are provided satisfactory proof of Your death as outlined in the Life Insurance Benefit provisions; and
3) the Policy and Your coverage are in force at the time of Your death.

How often is proof required?

We have the right to require proof that Your Total Disability continues. At Our option, We also have the right to require that a Doctor of Our choosing examine You. If an examination is required, it will be conducted at Our expense.

Such rights may be exercised at any reasonable time during the first 2 years following receipt of due proof of Your Total Disability. After this 2-year period such right may be exercised once a year.

When are premium payments no longer required?

Once We approve proof of Your Total Disability, Your Life Insurance will remain in force without further premium payments. Your Waiver of Premium Benefit will cease in accordance with the termination provision.

Are there any other benefits available under this provision?

If Your premiums are being waived due to Your Total Disability and You wish to return to work, We will assist You in identifying any modifications to Your worksite that are necessary to help You return to work. An agreement stating the modifications necessary for You to return to work must be signed by You, the Holder, and Us. In such case, We will reimburse the Holder for the cost of any agreed upon modifications up to a total maximum of $1,500.

When will Your Waiver of Premium Benefit terminate?

Insurance will immediately cease to be continued under this provision if:

1) proof of the continuance of Your Total Disability is not furnished when required;
2) You refuse to be examined as required;
3) Your Total Disability ends; or
4) You attain age 65.

Your insurance may then be continued in force under the Policy only if:

1) the Policy is then in force;
2) You immediately return to Active Work in a class eligible for insurance; and
3) premiums for You are paid as they fall due.

If either condition 1) or 2) above is not met, the termination of insurance will be subject to the Conversion Privilege.

How does termination of the Policy affect Your insurance under the Waiver of Premium Benefit?

Termination of the Policy will not affect any insurance that has been continued under this provision prior to the termination date.

What if You are Totally Disabled and the Policy ends before You satisfy the Elimination Period?

Your coverage under the Policy will end if the Policy terminates before You satisfy the Elimination Period. You will be entitled to convert Your coverage to an individual plan of life insurance as described in the Conversion Privilege provision.

You may still submit a claim for benefits after the Policy ends. However, You must be Totally Disabled for the full length of the Elimination Period. Termination of the Policy will not affect Your right to file claim for benefits once You qualify.

Upon receipt of timely notice and due proof of Your Total Disability, We will evaluate Your claim. If We determine that You qualify, We will approve Your claim and agree to rescind any individual policy of life Insurance issued to You under the Conversion Privilege. We will refund all premiums paid for such coverage. Insurance will not go in effect until We approve Your claim in writing.

TLWP-1AA-12

ACCELERATED BENEFIT

What is the Accelerated Benefit?

This benefit provides for an acceleration of Your Death Benefit, while You are living, if You are diagnosed with a terminal illness. If You qualify, We will pay an amount up to 70% of the amount of Your Life Insurance in force at the time of Your request, less any reductions which would occur within the next 12 months. The accelerated amount is subject to a minimum payment of $10,000 and a maximum of $250,000.

The Accelerated Benefit is payable only once during Your lifetime. It will be paid to You in a lump sum.

RECEIPT OF THE ACCELERATED BENEFIT MAY BE TAXABLE. WE ARE NOT RESPONSIBLE FOR ANY TAX OR OTHER EFFECTS OF ANY BENEFIT PAID. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR BEFORE ELECTING THIS BENEFIT.

How do You qualify for the Accelerated Benefit?

You may qualify for an Accelerated Benefit payment if:

1) the Policy including this benefit is in force with respect to You;
2) You are diagnosed by a Doctor as having a terminal illness with a life expectancy of 6 months or less;
3) no government agency requires You to use the payment to apply for, receive or continue a government benefit or entitlement;
4) Your claim under this provision is made during Your lifetime; and
5) You provide the following:
    a) a fully completed claim form;
    b) written consent from any assignee and/or irrevocable Beneficiary on claim forms provided by Us (or the Holder);
    c) a Doctor's statement certifying Your limited life expectancy;
    d) a second confirming medical opinion, if requested by Us. This will be by a Doctor acceptable to Us and at Our expense; and
    e) any additional information necessary to process the claim, as requested by Us.

Does Your premium change if You exercise the Accelerated Benefit option?

Your premium payments will continue to be paid on the full amount of Life Insurance in force prior to receiving the Accelerated Benefit.

How will the Accelerated Benefit Payment affect Your Life Insurance?

Your Life Insurance will be reduced by the amount of the Accelerated Benefit payment. Your remaining Life Insurance amount will be paid in accordance with the terms of the Policy, subject to any reduction and termination provisions.

The Principal Sum, if any, payable under the Accidental Death and Dismemberment Benefit is not affected by the Accelerated Benefit payment.

The amount You may convert to an individual policy, as outlined in the Conversion Privilege provision, will not exceed the amount of Your remaining Life Insurance.

When will this benefit terminate?

This provision will terminate on the date You are:

1) no longer insured under the Policy; or
2) issued the Accelerated Benefit payment;

whichever occurs first.

TLAB-1AA-12

PATHWAY PORTABILITY (CLASS 1 & 2 ONLY)

What is Pathway Portability?

Pathway Portability is Your right to continue Your Supplemental Life Insurance under either the Limited or Unlimited Portability Pathway. Continuation coverage is provided under a new group term life policy.

The amount of Life Insurance to be continued will not exceed the amount terminated under the Policy. Such amount will be reduced by any amount of group life insurance for which You are or become eligible within 31 days of termination. Waiver of Premium and other supplementary benefits will not be available. You will not be covered or receive benefits simultaneously under the Policy and the continuation policy.

What are the Pathway Portability options?

You may elect to continue Your Life Insurance under either of the following options:

1) Limited Portability Pathway: Under the Limited Portability Pathway, You will be allowed to continue Your coverage for a 3-year period. The rate charged will be the same as the group rate applicable to You at the time Your coverage ended under the Policy. No Proof of Insurability will be required.

2) Unlimited Portability Pathway: Under the Unlimited Portability Pathway, You will be allowed to continue Your coverage up to age 65. If You are between the ages of 60 and 65 when You request this option, You will be able to continue Your coverage for 5 years. If this option is elected, satisfactory Proof of Insurability is required.

   During the first 3 years of continuation coverage, You will be charged the same rate You were charged at the time Your coverage ended under the Policy. At the end of the 3-year period, the rate will change. The new rate will be based on Your attained age using a table of premiums applicable to all Insureds who have elected the Unlimited Portability Pathway.

How do You qualify for continuation of insurance?

You may continue Your insurance if the following conditions are met:

1) Your coverage terminates due to termination of employment;
2) You are under age 65;
3) You have been continuously covered under the Policy for at least 6 Months prior to the date that Your insurance terminates.

You may not continue any insurance under this provision if Your coverage terminates due to disability or retirement.

What must You do in order to continue Your insurance under this provision?

If You elect to continue Your insurance under this provision, You must:

1) notify Us in writing,
2) pay the first premium to Us, and
3) submit Proof of Insurability, if required;

within 31 days after Your insurance terminates. Your coverage under the continuation policy is effective as of the date that the above conditions are satisfied.

What happens when the continuation period ends?

Limited Portability Pathway: At the end of the 3-year continuation period, You may convert Your coverage to an individual policy of life insurance. Such conversion will be without further Proof of Insurability.

Unlimited Portability Pathway: If Your coverage under this option ends due to reaching the termination age, You will be allowed to convert Your coverage to an individual policy of life insurance without further Proof of Insurability. However, if You have elected the Unlimited Portability option and later choose to terminate the coverage, or Your coverage lapses due to nonpayment of premium, You will not be eligible to convert Your coverage to an individual policy of life insurance.

TLPO-1BA

ELIGIBILITY AND ENROLLMENT

Who are Your Eligible Dependents?

Dependents eligible for this coverage are as described in the Schedule. An Insured under the Policy may not be considered a Dependent.

When are You first eligible to elect Dependent coverage?

When You enroll for coverage for Yourself, You may also enroll for coverage for Your eligible Dependent. If You do not have an eligible Dependent, You may enroll for Dependent coverage within 31 days of the date You first acquire a Dependent.
TLCD-2AA

What if You do not elect Dependent coverage when first eligible?

If You do not elect Dependent coverage when first eligible, You may add such coverage at a later date. In such case, Your Dependent will be considered a Late Enrollee.
TLCD-3AA

EFFECTIVE DATES

When does Your Dependent's coverage start?

The insurance for a Dependent, up to the Guaranteed Issue Amount, will begin on:

1) The date Your coverage becomes effective, if You have enrolled for Dependent coverage on or before that date.
2) The date You enroll for Dependent coverage, if:
    a) You did not have any eligible Dependents when You first enrolled for coverage under the Policy;
    b) You subsequently acquire an eligible Dependent; and
    c) You enroll for Dependent coverage within 31 days of first acquiring such Dependent.
3) The date You enroll a newly acquired Dependent, if:
    a) Your Dependent insurance is in force at the time You acquire a new dependent; and
    b) You add Your newly acquired Dependent within 31 days of his first becoming eligible.
4) The first of the month that falls on or next follows the date We approve Your Dependent's Proof of Insurability, if required.

You must apply for any amounts over the Guaranteed Issue Amount. Such coverage will take effect on the first of the month that falls on or next follows the date We approve Your Dependent's Proof of Insurability.
TLCD-4AA

When will coverage become effective for Your Dependent who is disabled or confined in a hospital?
(This provision is not applicable to Dependents covered under the Prior Policy)

The effective date of insurance will be delayed if Your Dependent, other than a newborn Child, is disabled or confined in a hospital on the date his coverage would otherwise become effective. In such case, the Dependent's coverage will become effective on the later of:

1) The date he completely recovers and resumes normal activities; or
2) If employed, the first day after he is performing the material and substantial duties of his regular occupation on a full-time basis.

If a Dependent is a newborn Child and You have elected Dependent coverage prior to his birth, the newborn Child will be insured upon attaining the age specified in the Schedule. If you add Dependent coverage after the birth of Your Dependent Child and he is confined in a hospital, his insurance will become effective on the later of:

1) the date he attains the age specified in the Schedule; or
2) the date of his release from the hospital.

TLCD-6AA

CHANGES IN AMOUNTS OF INSURANCE

When does Your Dependent's coverage amount change if there is a change in Your class, Your earnings, or in the plan?

If there is an increase in Your Dependent's coverage amount due to a change in Your class, Your earnings, or the plan, Your Dependent's increased coverage amount will become effective on the later of:

1) the date Your Dependent becomes eligible for the increase; or
2) the first day of the month that falls on next follows the date Your Dependent's Proof of Insurability is approved by Us, if required.

If Your Dependent is disabled or confined in a hospital on the date his increase in coverage would otherwise become effective, the effective date of such increase will be delayed until the later of:

1) the date he completely recovers and resumes normal activities; or
2) if employed, the first day after he is performing the material and substantial duties of his regular occupation on a full-time basis.

If You are not Actively Working on the date the increase would otherwise take effect, it will take effect on the day after You return to Active Work for a period of 1 day.

Any type of decrease in coverage will become effective on the date of the change whether or not You are Actively at Work or Your Dependent is disabled or confined in a hospital.

TLCD-7AA

When will Your Dependent's coverage amount change due to age?

If Your Dependent has attained one of the benefit reduction ages stated in the Schedule, his coverage amount will be reduced. Any reduction will be in accordance with the reduction percentage shown for his age. All such reductions will take effect on the date of Your Dependent's change in age. If Your Dependent has already attained one of the reduction ages at the time his insurance goes into effect, a reduction will take place immediately.

For a Dependent Child, any change in the amount of insurance due to a change in age will take effect on the date of change.

TLCD-9AA

PROOF OF INSURABILITY FOR DEPENDENTS

When is Proof of Insurability required?

Proof of Insurability must be provided for Your Dependent if:

1 he is a Late Enrollee;
2) his amount of Life Insurance exceeds the Guaranteed Issue Amount stated in the Schedule;
3) You request an increase in his amount of Life Insurance; or
4) You request to reinstate Your Dependent insurance and Proof of Insurability is required by Us.

TLCD-10AA

DEPENDENT LIFE INSURANCE BENEFIT

What is Your Dependent's Death Benefit?

Your Dependent's Death Benefit is the amount of Dependent Life Insurance shown in the Schedule, subject to any reduction under the Policy. Death Benefits will be paid upon Our receipt of proof of Your Dependent's death.
TLCD-12AA

What happens if the cause of death is due to suicide? *(Applicable to Contributory coverage only)*

If Your Dependent dies as the result of suicide or any attempt at suicide, while sane or insane, within 2 years of his effective date of coverage, Our liability will be limited to a refund of the premiums actually paid for Your Dependent's Life Insurance.

With respect to any increase in the amount of insurance, We will consider the 2-year period to begin as of the effective date of such increase.

Our return of premiums will be in lieu of any benefits that would have been payable for such Dependent.
TLCD-13AA

What is needed before We can pay the Death Benefit?

Claims must be filed on Our forms. You may obtain a claim form from the Holder or Us.

The following are required before the Death Benefit can be paid:

1) a fully completed claim form;
2) a certified copy of the deceased's death certificate; and
3) any other documents that We may reasonably require to establish due proof of death.

After the required forms are received and approved by Us, the Death Benefit will be paid.
TLCD-14AA

CONVERSION PRIVILEGE

Under what conditions can Your Dependent's Life Insurance coverage be converted to another plan of insurance?

Your Dependent may convert his Life Insurance coverage to an individual policy if:

1) Your Dependent's coverage terminates, while the Policy is in force, and one of the following applies:
   a) Your employment ends;
   b) You are no longer a member of an Eligible Class;
   c) You are no longer in a class eligible for Dependent coverage;
   d) You die;
   e) he reaches a specified age; or
   f) he ceases to be a Dependent, as defined.

   The amount of life insurance may not exceed the amount for which Your Dependent was insured under the Policy.

2) Your Dependent has been continuously insured under the Policy for at least 5 years and his coverage terminates because the Policy terminates, or the Policy is amended so as to terminate insurance for his class.

   The amount of insurance for this insurance policy will be the lesser of:

   a) the amount for which Your Dependent was insured under the Policy. This amount will be reduced by any amount for which Your Dependent is or becomes eligible under any other group life insurance policy within 31 days of termination; or

   b) $10,000.

TLCD-18AA

How does Your Dependent convert coverage?

To convert his Life Insurance coverage Your Dependent must:

1) Make written application to Us within:
   a) 60 days of the termination of his insurance due to Your death; or
   b) 31 days of the termination of his insurance in all other cases;
2) Include the first premium payment with his application. The premium will be based on the rates filed by Us for the policy to be issued. It will also be based on his age and class of risk and the amount of insurance.

When We receive Your Dependent's written application and first premium payment, We will issue him an individual life insurance policy. The issuance of the policy will be subject to the following conditions:

1) no Proof of Insurability is needed;
2) the individual policy will be on one of the forms, except term insurance, that We issue for conversion coverage; and
3) the individual policy may not contain disability, accidental death and dismemberment or other supplementary benefits.

Any individual policy issued under this Conversion Privilege will be in lieu of all other benefits under the Policy.
TLCD-19AA

What if Your Dependent dies during the conversion election period?

If Your Dependent dies within the 31-day conversion period, We will, upon receipt of proof of Your Dependent's death, pay the amount of life insurance that Your Dependent was entitled to convert. The claim will be paid under the Group Policy, even if the application or payment of the first premium for the individual policy has not been made.
TLCD-20AA

What happens if Your Dependent converts his coverage and later becomes eligible again for coverage under the Policy?

If Your Dependent has converted his coverage to an individual policy he will not have to surrender such policy if he becomes insured again under the Policy. If Your Dependent once again becomes ineligible for coverage under the Policy, he will not be able to convert his coverage a second time if his original conversion policy is still in force.
TLCD-21AA

What are the notice requirements for conversion?

We or the Holder will notify Your Dependent in writing of his rights to convert his coverage under the Policy. If the notice is not received within 31 days after insurance terminates, the application period for conversion may be extended for an additional 60 days. In no event, will the application period exceed 91 days following the date of his termination.
TLCD-22AA

DEPENDENT LIFE ACCELERATED BENEFIT

What is the Dependent Life Accelerated Benefit?

This benefit provides for an acceleration of Your Dependent's Death Benefit, while he is living, if he is diagnosed with a terminal illness. If Your Dependent qualifies, We will pay an amount up to 50% of the amount of his Life Insurance in force at the time of Your request, less any reductions which would occur within the next 12 months. The accelerated payment is subject to a minimum of $10,000 and a maximum of $50,000.

The Accelerated Benefit is payable only once during Your Dependent's lifetime. The Benefit is paid to You in a lump sum.

RECEIPT OF THE ACCELERATED BENEFIT MAY BE TAXABLE. WE ARE NOT RESPONSIBLE FOR ANY TAX OR OTHER EFFECTS OF ANY BENEFIT PAID. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR BEFORE ELECTING THIS BENEFIT.

How does Your Dependent qualify for the Accelerated Benefit?

Your Dependent may qualify for an Accelerated Benefit if:

1) the Policy including this benefit is in force with respect to You and Your Dependent;
2) he is diagnosed by a Doctor as having a terminal illness with a life expectancy of 12 months or less;
3) he becomes terminally ill while insured under the Policy or this benefit provision, whichever is later;
4) no government agency requires You to use the payment to apply for, receive or continue a government benefit or entitlement;
5) Your claim under this provision is made during Your Dependent's lifetime; and
6) You provide the following:
    a) a fully completed claim form;
    b) written consent from any assignee and/or irrevocable beneficiary on claim forms provided by Us (or the Holder);
    c) a Doctor's statement certifying Your Dependent's limited life expectancy;
    d) a second confirming medical opinion, if requested by Us. This will be by a Doctor acceptable to Us and at Our expense; and
    e) any additional information necessary to process the claim, as requested by Us.

Does Your premium change if You exercise the Accelerated Benefit option?

Once an Accelerated Benefit has been paid Your premium will not change. Your premium payments will continue to be paid on the full amount of Life Insurance in force prior to receiving the Accelerated Benefit.

How will the Accelerated Benefit Payment affect Your Dependent's Life Insurance?

Your Dependent's Life Insurance will be reduced by the amount of the Accelerated Benefit payment. His remaining Life Insurance amount will be paid according to the terms of the Policy, subject to any reduction and termination provisions.

The amount Your Dependent may convert to an individual policy, as outlined in the Conversion Privilege provision, will not exceed the amount of his remaining Life Insurance.

When will this benefit terminate?

This provision will terminate on the date Your Dependent is:

1) no longer insured under the Policy; or
2) issued the Dependent Life Accelerated Benefit Payment;

whichever first occurs.

TLDAB-1AA

TERMINATION OF EMPLOYEE INSURANCE

When does Your insurance terminate?

Your insurance coverage will end on the earliest of the following dates:

1) the date the Policy is terminated;
2) the date You request to cancel Your coverage under the Policy;
3) the date at the end of the period for which premium has been paid, if the required premium is not paid within the Grace Period;
4) on the date:
    a) You are no longer a member in an Eligible Class; or
    b) Your class is no longer covered under the Policy;
5) the date You enter the armed forces of any country. Membership in the reserves or a call to active duty for 2 months or less is not deemed entry into the armed forces.
6) the date the Death Benefit is paid.

TLC-21AA

5) the date You enter the armed forces of any country. Membership in the reserves or a call to active duty for 1 months or less is not deemed entry into the armed forces.
6) the date the Death Benefit is paid.

TLC-21AA

If the required premium is paid when due, absence due to the following will not be treated as a termination of Your Life Insurance until the end of the period shown:

- Leave of absence, agreed to in writing by Your employer: 1 month(s)
- Temporary layoff: 1 month(s)

TLC-24BA

Under what conditions can coverage be reinstated after termination?

Your coverage may be reinstated under the Policy if:

1) Your coverage ends due to termination of employment;
2) You become eligible again within 12 months of Your termination; and
3) You make written request for reinstatement within 31 days of becoming eligible.

You will be considered a Late Enrollee if You are eligible to reinstate Your coverage, but fail to make such request within the above time limit.

If the above conditions are satisfied, Your coverage will take effect on the date Your reinstatement request is accepted by the Holder or Us. The amount of insurance reinstated will be the amount in force at the time Your employment ended, subject to any reduction due to age.

Life Insurance continued under any Portability provision must be surrendered before Your coverage will be reinstated. Life Insurance continued under the Portability provision may not be reinstated.

TLC-26AA

Under what conditions can coverage be reinstated after termination?

Your coverage may be reinstated under the Policy if:

1) Your coverage ends due to termination of employment;
2) You become eligible again within 12 months of Your termination; and
3) You make written request for reinstatement within 31 days of becoming eligible.

You will be considered a Late Enrollee if You are eligible to reinstate Your coverage, but fail to make such request within the above time limit.

If the above conditions are satisfied, Your coverage will take effect on the date Your reinstatement request is accepted by the Holder or Us. The amount of insurance reinstated will be the amount in force at the time Your employment ended, subject to any reduction due to age.
TLC-26AA

TERMINATION OF DEPENDENT'S INSURANCE

When does Your Dependent's coverage end?

Dependent's coverage will end on the earliest of:

1) the date Your coverage terminates;
2) the date the Policy terminates;
3) the date You cancel Your Dependents' insurance;
4) the date at the end of the period for which the last premium has been paid if the required premium is not paid within the Grace Period;
5) the date the Dependent ceases to be an eligible Dependent;
6) the date You are no longer in a class eligible for Dependents' insurance;
7) the date Your Dependent enters the armed forces of any country. Membership in the reserves, or a call to active duty for 2 months or less is not deemed entry into the armed forces;
8) the date of termination of Dependents' insurance under the Policy;
9) the date the Death Benefit is paid;
10) with respect to spouses, the date of the final decree of divorce;
11) the date You elect Portability.

TLCD-15AA

Under what conditions can Your handicapped Child's coverage be continued?

We will continue coverage beyond the termination age for Your Dependent Child who is:

1) not capable of self-support due to physical or mental handicap; and
2) dependent upon You or other care providers for lifetime care and supervision.

Coverage for such Dependent Child will continue while he remains handicapped, and Your coverage stays in force.

Other care providers means a Community Integrated Living Arrangement, group home, supervised apartment or other residential services licensed or certified by the Department of Mental Health and Development Disabilities, the Department of Public Health or the Department of Public Aid.
TLCD-17AA-12

BENEFICIARY AND PAYMENT OF CLAIMS

How do You designate or change Your Beneficiary?

At the time You become insured, You should name a Beneficiary to receive Your death proceeds payable under the Policy.

It is important that You name a Beneficiary and keep Your designation current. You may name a new Beneficiary at any time by filing with the Holder a written request on forms acceptable to Us. The Holder will send the request to Us upon Your death. When the request is received by Us from the Holder, the change will relate back to and take effect as of the date it was signed. This is the case whether You are alive or not when We receive the request. Even though the change of Beneficiary will relate back to the date it was signed, it will be without prejudice to Us on account of any payment We have already made.
TLC-33AA

To whom are benefits payable?

Payment of Your Life Insurance Death Benefit will be made in a lump sum to Your Beneficiary. In lieu of a lump sum payment, an optional method of settlement may be selected as stated in the provision entitled *Can You choose an Optional Method of Settlement*. All other benefits will be paid to You.
TLC-34BA

Dependent Death Benefits will be paid in a lump sum to You. If You should die before receiving the insurance proceeds, We will pay them to Your estate.
TLC-35AA

If a Beneficiary dies simultaneously with You, or within 10 days of Your death, benefits will be paid as if You survived Your Beneficiary.
TLC-36AA

If You name more than one Beneficiary and do not specify the amounts, percentage shares, or order of payment of the Beneficiaries, any proceeds that become payable under the Policy will be divided equally among all Beneficiaries. The share of any Beneficiary who has died before You will go equally to the surviving Beneficiaries, unless Your Beneficiary designation states otherwise.

If a Beneficiary is a minor or is not legally competent, We may, at Our option, pay up to $2,000 to the person or entity that has in Our opinion assumed custody and main support of such person. We will do this until the Beneficiary's legal guardian makes a formal claim.

At Our option, We may pay a part of the Death Benefit to any person who has incurred funeral or other expenses on Your behalf incident to Your last sickness and death. The maximum amount of such payment is limited to the lesser of $1,000 or the maximum amount allowed by law.

Any payment made by Us in good faith, will fully discharge Our liability to the extent of such payment.
TLC-37AA

What if there is no valid Beneficiary designation in effect at the time ofYour death?

Your death proceeds will be paid to Your estate if:

1) You die without naming a Beneficiary; or
2) all of Your Beneficiaries have died before You.

If payment would otherwise be payable to Your estate due to the above, We have the right to pay all or a part of the benefit to the first of the following classes of surviving relatives: Your spouse; Your children; Your parents; or Your siblings.

Any payment made by Us in good faith, will fully discharge Our liability to the extent of such payment.
TLC-38AA

GENERAL PROVISIONS

How will Your statements made in any application for this insurance be used?

Any statement made by You will be deemed a representation and not a warranty. No statement will be used to void or reduce benefits, or be used in defense to a claim unless:

1) it is in writing;
2) it was signed by You; and
3) a copy has been given to You, Your Beneficiary or Your personal representative.

We will not use any statement to contest the validity of Your insurance after it has been continuously in force under the Policy for a period of 2 years during Your lifetime. With respect to an increase in the amount of Your insurance, We will consider the 2-year period to begin as of the effective date of such increase.
TLC-39AA

Can You choose an Optional Method of Settlement?

Your Death Benefit will be paid to Your Beneficiary in a lump sum. In lieu of a lump sum payment, You may elect to have all or a part of Your insurance proceeds paid in a fixed number of monthly installments. If You have not made such election, Your Beneficiary may do so. Election must be made by filing written request with Us at Our Home Office.

The amount of each monthly payment, according to the number of years elected, is shown in the table below:

Number of Years of Payment	**3**	**4**	**5**	**10**	**15**	**20**
Monthly Installment for each $1,000 of Death Benefits	$28.99	$22.06	$17.91	$9.61	$6.87	$5.51

The first payment will be made immediately upon receipt of proof of death. A period of years resulting in monthly payments of less than $50 may not be selected.

If Your Beneficiary dies while receiving monthly payments, the present value of the remaining payments will be paid to the Beneficiary's estate unless You or Your Beneficiary has designated an alternate payee by prior written election. The present value will be determined by using a 3% per year interest factor.

We may change the above table on any Policy anniversary date. We may also change the table on any date the provisions of the Policy are changed. Any new table will not apply to any claim pending under the Policy before the date of the change.
TLC-43AA

Can You assign Your Ownership Rights?

Your right, title, and interest in the Policy are evidenced by the certificate. You may assign such right, title, and interest to someone else (known as an assignee). This assignment will cover all of Your ownership rights under the Policy including, but not limited to the following:

1) the right to change the Beneficiary;
2) the right to receive any and all benefits under the Policy without notice to or consideration to You; or
3) any right to convert this group insurance to an individual policy of life insurance in accordance with the Conversion Privilege.

We will recognize an assignee as the owner of the rights assigned only if:

1) the assignment is in writing, signed by You, and on a form approved by Us; and
2) a signed or certified copy of the written assignment has been received and registered by Us.

You cannot assign Your Life Insurance as collateral for a loan.

We will not be responsible for the legal, tax or other effects of any assignment; or for any action taken under the Policy's provisions before receiving and registering an assignment.
TLC-44AA

Are proceeds protected from the claims of the Beneficiary's creditors?

The benefits under the Policy are not subject to the claim of or legal process by any creditor of Your Beneficiary.
TLC-45AA

What if the age or sex of someone covered under the Policy is misstated?

If the age or sex of a person covered under the Policy has been misstated, We will make an equitable adjustment of the premium. Such adjustment will be the difference between the premiums paid and the premiums which would have been paid at Your true age or sex, whichever applies.

If coverage would not have been issued, We will refund the premiums paid for such insurance.
TLC-46AA

What happens if there is a record keeping error?

An error in keeping records will not cancel insurance that should otherwise continue in force. Such error will not continue insurance that should otherwise end. Your insurance coverage will not be prejudiced by the failure on the part of the Holder to transmit reports, pay premium or comply with any of the provisions of the Policy when such failure is due to an inadvertent error or clerical mistake.
TLC-48AA

DEFINITIONS

The following are key words and phrases used in this certificate. When these words and phrases, or forms of them, are used, they are capitalized. As You read this certificate, refer back to these definitions.
TLD

Active Work, Actively at Work, or ***Actively Working*** means You must be:

1) working at Your employer's usual place of business, or on assignment for the purpose of furthering the employer's business; and

2) performing the Material and Substantial Duties of Your regular occupation on a full-time basis.
TLD-2AA

Appropriate and Regular Care means that You are regularly visiting a Doctor as frequently as medically required to meet Your basic health needs. The effect of the care should be of demonstrable medical value for Your disabling condition(s) to effectively attain and/or maintain Maximum Medical Improvement.
TLD-3AA

Basic Annual Salary is as stated in the Schedule.
TLD-4AA

Beneficiary means the person, persons or entity You name to receive Your Life Insurance Death Benefit.
TLD-5AA

Child means Your birth child or an adopted child beginning on the date of placement for purposes of adoption. A Child also includes Your stepchild, foster child, or any other child who has a parent-child relationship with You. Such child must depend upon You for support.
TLD-6AA

Contributory means that coverage for which You pay all or a part of the premium.
TLD-8AA

Covered Person means You and Your insured Dependents who are covered under the Policy.
TLD-9AA

Death Benefit means the amount of Life Insurance stated or described in the Schedule, less any reductions.
TLD-10AA

Dependent is as described in the Schedule.
TLD-11AA

Doctor means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither You nor a member of Your Immediate Family. A licensed medical practitioner is a Doctor if applicable state law requires that such practitioners be recognized for purposes of certification of disability, and the treatment provided by the practitioner is within the scope of his license.
TLD-12AA

Eligible Person or Eligible Persons means a person or persons in an Eligible Class under the Policy. With respect to this Certificate, eligible persons are those persons in an Eligible Class shown in the Schedule.
TLD-13AA

Eligible Class means a class of persons eligible for insurance under the Policy. With respect to this Certificate, the class or classes eligible for insurance are as described in the Schedule.
TLD-14AA

Elimination Period means the period of continuous Total Disability stated in the Schedule.
TLD-15AA

Family Status Change or Family Status Changes means those changes shown in the table of Family Status Changes located in this Certificate.
TLD-16AA

Gainful Occupation means the performance of any occupation or employment for wages, remuneration or profit, for which You are reasonably qualified by education, training or experience. Such occupation can be on a full-time or part-time basis.
TLD-17AA

Generally Accepted Medical Practice or Generally Accepted in the Practice of Medicine means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
TLD-18AA

Guaranteed Issue Amount means the amount of Life Insurance stated in the Schedule that is not subject to Proof of Insurability requirements. A Covered Person's Guaranteed Issue Amount is only available when he first becomes eligible to enroll. It is not available to a Late Enrollee.
TLD-19BA

Immediate Family means Your spouse and the children, siblings and parents of either You or Your spouse.
TLD-20AA

Insured means the employee whose insurance is in force under the terms of the Policy.
TLD-22AA

Late Enrollee means You enroll for coverage more than 31 days after You are first eligible to enroll.

Late Enrollee with regard to Your Dependent means that You enroll for Dependent coverage more than 31 days after Your Dependent's initial eligibility period. You or Your Dependent will also be considered a late enrollee if You were eligible under the Prior Policy for more than 31 days but were not insured.
TLD-23BA

Male pronoun whenever used includes the female.
TLD-24AA

Material and Substantial Duties means the necessary functions of Your regular occupation which cannot be reasonably omitted or altered.
TLD-25AA

Maximum Medical Improvement is that level at which, based on reasonable medical probability, further material recovery from, or lasting improvements to an injury or sickness can no longer be reasonably anticipated.
TLD-26AA

Medical Advice means advice, care, or treatment from Your Doctor which is consistent with Generally Accepted Medical Practice.
TLD-27AA

Non-Contributory means that coverage for which the Holder pays the entire premium.
TLD-29AA

Prior Policy means the Holder's group life insurance policy that was:

1) in force immediately prior to the effective date of the Policy; and
2) replaced by the Policy.

TLD-30AA

Proof of Insurability means a written statement of the medical history for a person eligible for coverage under the Policy. It includes any proofs that might reasonably be required in order to determine acceptability for coverage in accordance with Our established underwriting criteria.
TLD-31AA

Schedule means the Schedule of Benefits which is a part of this Certificate.
TLD-33AA

Total Disability or ***Totally Disabled*** means that as a result of injury or sickness, You are unable to perform each of the material duties of any Gainful Occupation.
TLD-35AA

Total Disability will not be deemed to exist unless You are receiving Appropriate and Regular Care for Your condition from a Doctor and are following his Medical Advice.
TLD-36AA

Waiting Period means the continuous length of time that You must be Actively Working in an Eligible Class before becoming eligible to enroll for coverage. The Waiting Period is stated in the Schedule.
TLD-37AA

We, Our and ***Us*** mean the Continental Assurance Company, Chicago, Illinois.
TLD-38AA

You, Your and ***Yours*** mean the eligible employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.
TLD-39AA

YOUR RIGHTS UNDER ERISA

The following section contains information provided to You by the Plan Administrator of Your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974. It does not constitute a part of the Plan or of any insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan

The Plan for which this Summary Plan Description is provided is known as the PSC Group Life Plan.

Maintenance of Plan

The Plan is maintained by:

PSC
9700 Higgins Road, Suite 750
Rosemont, IL 60018

Employer Identification Number and Plan Number

The employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor is 98-0131394.

The plan number assigned by the plan sponsor is 502.

Type of Welfare Plan

The Plan is a group life plan.

Administration of Plan

The Plan is administered by the Plan Administrator through an insurance contract purchased from Continental Assurance Company.

Plan Administrator

Hereinafter referred to as the Administrator. The Administrator has the discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan.

Agent for Service of Legal Process

The person designated as agent for service of legal process upon the Plan:

In addition, service of process may be made upon the Administrator.

Eligibility and Benefits

The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits are specified in the certificate section of this booklet.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits are specified in the certificate section of this booklet.

The Plan Sponsor/Administrator reserves the right at any time to modify or amend, in whole or in part, any of the provisions of the Plan.

Sources of Plan Contributions

Contributions to the Plan are made by the employer and employee.

Medium for Providing Benefits

Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number(s) SR-83120548 issued by Continental Assurance Company, CNA Plaza, Chicago, Illinois 60685. Benefits under the Plan are not guaranteed under the Group Insurance Policy. The administrative services provided by Continental Assurance Company include the payment of claims, premium billing, eligibility administration and policy and certificate issuance.

Date of End of Plan's Fiscal Year

The date of the end of each year for purposes of maintaining the Plan's fiscal records is January 1.

Claim Procedures

A) Presenting Claims for Benefits

Claim forms may be obtained from: Employer.

Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

B) Claims Denial Procedure

Any denial of a claim for benefits will be provided by the Administrator and consist of a written explanation which will include:

1) the specific reasons for the denial;
2) reference to the pertinent plan provisions upon which the denial is based;
3) a description of any additional information You might be required to provide and explanation of why it is needed; and
4) an explanation of the Plan's claim review procedure.

You, Your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the Administrator. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the Administrator, no later than 60 days after receipt of the request for review. If there are special circumstances, the decision will be made as soon as possible, but not later than 120 days after receipt of the request for review. If such an extension of time is needed, You will be notified in writing prior to the beginning of the time extension period. The decision after Your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent plan provisions on which the decision is based.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in this Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and union halls, all plan documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries.

No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

If Your claim for a welfare benefit is denied in whole or in part You must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider Your claim.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials for the Plan and do not receive them within 30 days, You may file suit in federal court. In such a case, the court may require the Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay the cost and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about Your plan, You should contact the Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

ERISA

COMPLAINT NOTICE

THIS NOTICE IS TO ADVISE YOU THAT ANY COMPLAINTS REGARDING THIS GROUP INSURANCE PLAN MAY BE DIRECTED TO:

CNA Insurance Companies
Attn: Consumer Affairs Department – 16S
CNA Plaza
Chicago, IL 60685

and/or

Illinois Department of Insurance
Consumer Division or Public Service Section
Springfield, IL 62767

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(312) 714-8050

Illinois Department of Insurance
320 West Washington Street, 4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary and General Purposes and Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law. The following contains a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

Coverage

The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

- Life insurance, health insurance and annuity contracts;
- Life, health or annuity certificates under direct group policies or contracts;
- Unallocated annuity contracts; and
- Contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees or assignees of such persons are also protected, even if they live in another state.

Exclusions

The Guaranty Association does not provide coverage for:

- Any policy or portion of a policy for which the individual has assumed the risk;
- Policy of reinsurance (unless an assumption certificate was issued);
- Interest rate guarantees which exceed certain statutory limitations;
- Certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
- Any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
- Any stop loss insurance.

In addition, persons are not protected by the Guaranty Association if:

- The Illinois Director of Insurance determines that, in the case of an insurer which is domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
- Their policy was issued by an organization which is not a member insurer of the Association.

Limits on Amounts of Coverage

The law limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or
- With respect to any one life, regardless of the number of policies, contracts or certificates:
  - In the case of Life insurance, $300,000. in death benefits but not more than $100,000. in net cash surrender or withdrawal values;
  - In the case of health insurance, $300,000. in health insurance benefits, including net cash surrender or withdrawal values; and
- With respect to annuities, $100,000. in the present value of annuity benefits, including net cash surrender or withdrawal values, and $100,000. in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $5,000,000. in benefits per contract holder, regardless of the number of contracts.

However, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

BG15430-A12

PHILIP SERVICES CORP
Industrial Services Group
Northeast Region

August 15, 2000

Mr. Ron Ditomasso

Dear Ron:

You are eligible to join the Philip Services/North Atlantic, Inc. group health program. Enclosed is information on the medical, dental, vision, supplemental life, dependent life and long term disability insurance.

Please complete the Philip insurance enrollment form and send it back to me on or before September 1, 2000. This is the day your insurance will begin. If you do not complete the form and send it to me by September 1, 2000, **you still have 30 days to choose coverage with a new effective date of October 1, 2000.** If you choose not to join at this time, complete the form waving coverage. Also, be advised when you do want insurance you will have to wait until January 1, 2001.

If you have any questions on any portion of this information, please give me a call in Portland at 800-427-0746 extension 121 between 7:00 a.m. and 3:30 p.m. Monday through Friday.

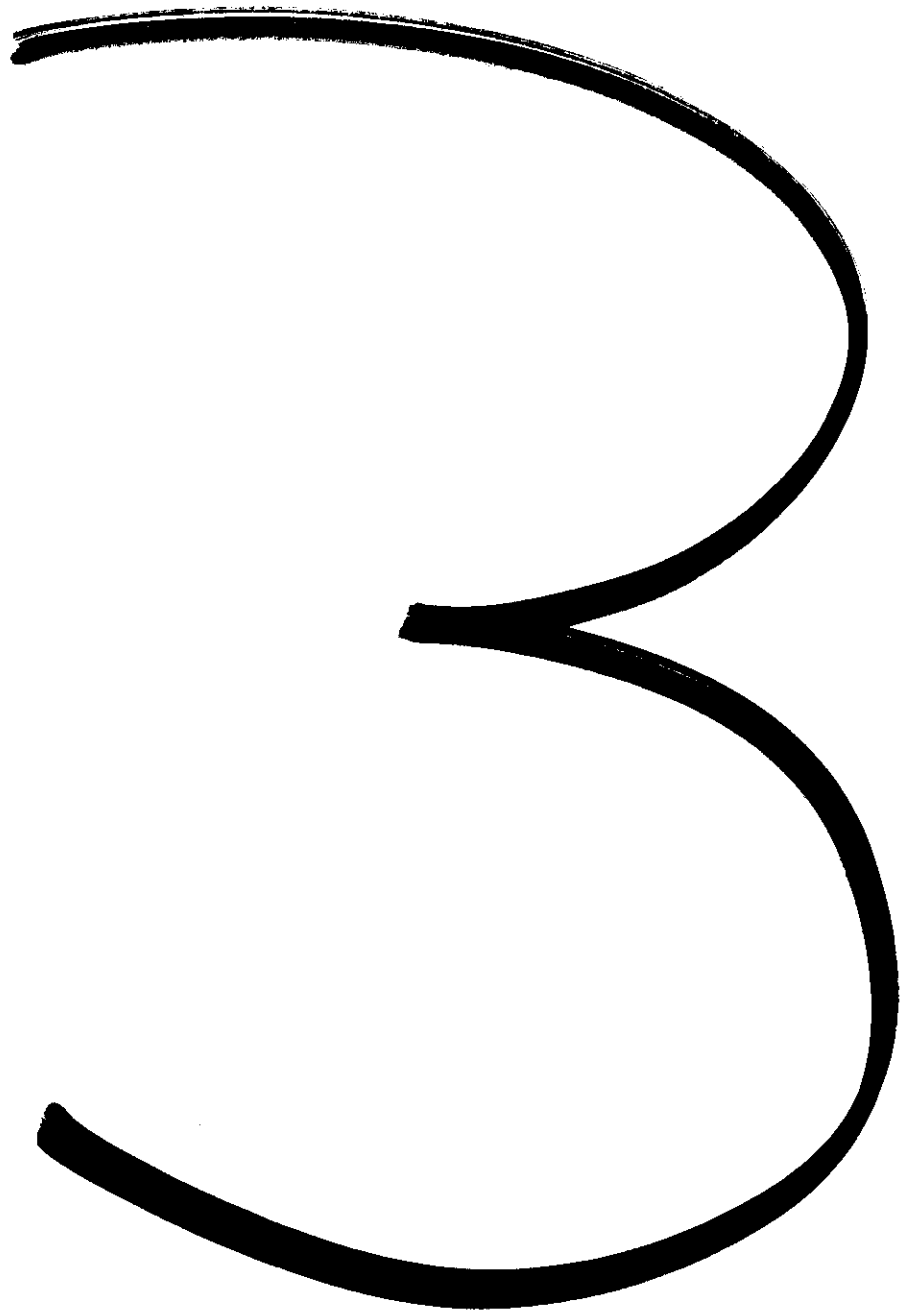
Sincerely,

PHILIP SERVICES/NA

Cindy

Cynthia M. Demers
Benefits Administrators

* Call me for a list of doctors.



PSC Powdered 170 D.M Partner Cider

EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

CHECK ONE: ☒ NEW ENROLLMENT ☐ ADD DEPENDENT(S) ☐ CANCEL DEPENDENT(S) ☐ CHANGE EMPLOYEE ☐ TRANSFER TO ANOTHER PLAN

NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER
DiTOMASSO RONALD J	028-38-7269	—
STREET ADDRESS	**CITY**	**STATE** / **ZIP**
128 WORCESTER RD, PO BOX 642	CHARLTON	MA / 01507
HOME TELEPHONE NUMBER	**HIRE DATE**	**EFFECTIVE DATE**
508 2489515	~~10/28/90~~ 5-30-00	11/1/02

LOCATION 202 / 148

☐ SALARIED ☒ HOURLY ☐ CASUAL HOURLY

42 37 70 2

HEALTH PLAN

MEDICAL PLAN OPTIONS (PLEASE CHECK ONE)
- ☐ POINT OF SERVICE PLAN
- ☒ PPO - HIGH OPTION PLAN
- ☐ PPO - LOW OPTION PLAN
- ☐ OUT OF AREA
- ☐ OTHER _____
- ☐ NO COVERAGE

TYPE OF COVERAGE (PLEASE CHECK ONE)
- ☒ EMPLOYEE ONLY
- ☐ EMPLOYEE + CHILD(REN)
- ☐ EMPLOYEE + SPOUSE
- ☐ EMPLOYEE + FAMILY
- ~~☐ EMPLOYEE + DOMESTIC PARTNER~~

DENTAL ☐ PPO ☐ HMO (PLEASE CHECK ONE)
- ☐ EMPLOYEE ONLY
- ☐ EMPLOYEE + CHILD(REN)
- ☐ EMPLOYEE + SPOUSE
- ☐ EMPLOYEE + FAMILY
- ☐ EMPLOYEE + DOMESTIC PARTNER
- ☒ NO COVERAGE

VISION (PLEASE CHECK ONE)
- ☒ EMPLOYEE ONLY
- ☐ EMPLOYEE + CHILD(REN)
- ☐ EMPLOYEE + SPOUSE
- ☐ EMPLOYEE + FAMILY
- ☐ NO COVERAGE

EMPLOYEE AND DEPENDENT INFORMATION

The following section must be completed if you elected to participate in one or more of the plans above. Complete the primary care physician section only if you elected to participate in the Point of Service option or the DHMO option.

Name (Last, First, M.I.)	Date of Birth	Sex	Full-time Student	PCP Number	Existing Patient?	Policy Code
Self: DiTOMASSO, RONALD J	9 14 48	M ☒ F ☐		POS-PCP NUMBER	Yes ☐ No ☐	
Social Security Number: 028 38 7269				Dental Office Selection	Yes ☐ No ☐	
Spouse/Domestic Partner: LINDA L REINHOLD	5 11 51	M ☐ F ☒		POS-PCP NUMBER	Yes ☐ No ☐	
Social Security Number: 024 42 0275				Dental Office Selection	Yes ☐ No ☐	
Child	/ /	M ☐ F ☐	Y ☐ N ☐	POS-PCP NUMBER	Yes ☐ No ☐	
Social Security Number				Dental Office Selection	Yes ☐ No ☐	
Child	/ /	M ☐ F ☐	Y ☐ N ☐	POS-PCP NUMBER	Yes ☐ No ☐	
Social Security Number				Dental Office Selection	Yes ☐ No ☐	
Child	/ /	M ☐ F ☐	Y ☐ N ☐	POS-PCP NUMBER	Yes ☐ No ☐	
Social Security Number				Dental Office Selection	Yes ☐ No ☐	

For Office Use Only

ELIGIBILITY JAN 2 1 2002 ENTERED BY LESLIE

Is spouse employed? ☐ No ☐ Yes Name of employer _____

Does spouse have other Insurance Coverage? ☐ No ☐ Yes Name of Company _____

Do children have other Insurance Coverage? ☐ No ☐ Yes Name of Company _____

BASIC LIFE AND AD&D

PSC provides all eligible employees Basic Life/Accidental Death and Dismemberment insurance coverage in the amount of employee's base annual salary up to $500,000. PLEASE COMPLETE THE BENEFICIARY SECTION BELOW. (If a beneficiary is not named below, any proceeds will be paid according to the terms of the policy.)

BENEFICIARY DESIGNATION (BASIC LIFE/AD&D/SUPPLEMENTAL LIFE/VOLUNTARY AD&D)

PRIMARY BENEFICIARY
LINDA L REINHOLD — NAME
DOMESTIC PARTNER — RELATIONSHIP

CONTINGENT BENEFICIARY
JAMES + ANTHONY DITOMASSO — NAME
SONS — RELATIONSHIP

92 7.

SUPPLEMENTAL LIFE INSURANCE MAY BE SUBJECT TO EVIDENCE OF INSURABILITY

CHECK ONE ☒ SMOKER ☐ NON SMOKER (Must not have used tobacco or nicotine products in the last 12 months)

☒ 1 X BASE SALARY ☐ 2 X BASE SALARY ☐ 3 X BASE SALARY ☐ 4 X BASE SALARY ☐ 5 X BASE SALARY ☐ NO COVERAGE

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT

CHECK ONE ☐ EMPLOYEE ONLY PLAN ☐ FAMILY PLAN

☐ 1 X BASE SALARY ☐ 2 X BASE SALARY ☐ 3 X BASE SALARY ☐ 4 X BASE SALARY ☐ 5 X BASE SALARY ☑ NO COVERAGE

SPOUSE AND DEPENDENT CHILD(REN) LIFE - MUST HAVE SUPPLEMENTAL LIFE

SPOUSE COVERAGE (CHECK ONE) Cannot Exceed 50% of Employee Coverage

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000
☐ $80,000 ☐ $90,000 ☐ $100,000 ☒ No Coverage

SPOUSE NAME _____

SPOUSE BIRTHDATE ___/___/___

SPOUSE SOCIAL SECURITY NUMBER ___/___/___

☐ SMOKER ☐ NON-SMOKER (Must not have used tobacco or nicotine products in the last 12 months)

Please complete this Evidence of Insurability form for amounts of insurance over $20,000.

CHILD(REN) COVERAGE (CHECK ONE)
- ☐ $2,000
- ☐ $4,000
- ☐ $6,000
- ☐ $8,000
- ☐ $10,000
- ☑ No Coverage

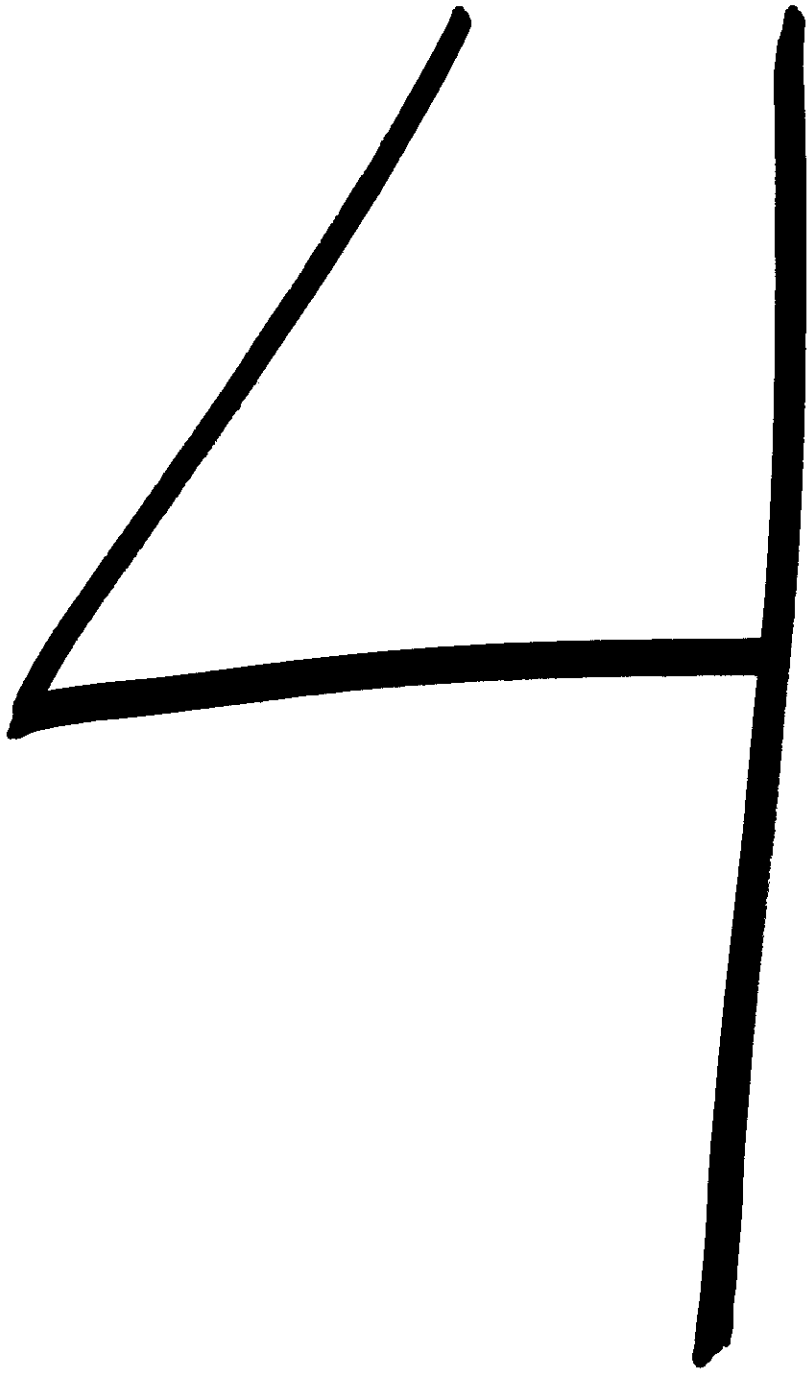
I understand that misstatements, misrepresentation, or omissions may result in my coverage being void as of its effective date with no benefits payable. I hereby request the group coverage for which I am or may become eligible and authorize deductions from my earnings to serve as payment for any required contributions. My signature below affirms that all information and statements provided on this form are full, complete, and true to the best of my knowledge.

I have selected The Philip Services Health Care Plan for my coverage. I authorize any physician, other health professional, all hospitals and other health care institutions to provide Health Care information concerning health care advice, treatment or supplies provided my dependents and/or myself relating to coverage under this plan.

I have read the explanation of my benefits options. I authorize the above elections and required pre-tax contributions for these elections. I understand that I cannot change or revoke these elections until the next open enrollment period unless there is a change in family status as defined by the Internal Revenue Service. I understand that I have 31 days from my effective date to provide this form to my benefits representative with my election option. If I do not turn in this form within this time period, I understand I will have waived my right to enter plans with pre-tax contributions until the next open enrollment period. I authorize my employer to make the necessary deductions from my wage or salary to pay my premiums for this coverage.

Ronald J. DiTomasso
EMPLOYEE SIGNATURE

SHARED SERVICE COPY 12/10/01



EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

CHECK ONE: ☐ NEW ENROLLMENT ☒ ADD DEPENDENT(S) ☐ CANCEL DEPENDENT(S) ☐ CHANGE EMPLOYEE ☐ TRANSFER TO ANOTHER PLAN

NAME-(LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	EMPLOYEE NUMBER
DITOMASSO RONALD J	028 - 38 - 7269	
STREET ADDRESS	**CITY**	**STATE** / **ZIP**
128 WORCESTER ROAD, PO BOX 642	CHARLTON	MA / 01507
HOME TELEPHONE NUMBER	**HIRE DATE**	**EFFECTIVE DATE** / **LOCATION**
508 248 9515	5/30/00	2/1/02 / 148

☐ SALARIED ☒ HOURLY ☐ CASUAL HOURLY

HEALTH PLAN

MEDICAL PLAN OPTIONS (PLEASE CHECK ONE)
- ☐ POINT OF SERVICE PLAN
- ☒ PPO - HIGH OPTION PLAN
- ☐ PPO - LOW OPTION PLAN
- ☐ OUT OF AREA
- ☐ OTHER _____
- ☐ NO COVERAGE

TYPE OF COVERAGE (PLEASE CHECK ONE)
- ☐ EMPLOYEE ONLY
- ☐ EMPLOYEE + CHILD(REN)
- ☒ EMPLOYEE + SPOUSE
- ☐ EMPLOYEE + FAMILY
- ☐ EMPLOYEE + DOMESTIC PARTNER

DENTAL ☐ PPO ☐ HMO (PLEASE CHECK ONE)
- ☐ EMPLOYEE ONLY
- ☐ EMPLOYEE + CHILD(REN)
- ☐ EMPLOYEE + SPOUSE
- ☐ EMPLOYEE + FAMILY
- ☐ EMPLOYEE + DOMESTIC PARTNER
- ☒ NO COVERAGE

VISION (PLEASE CHECK ONE)
- ☐ EMPLOYEE ONLY
- ☐ EMPLOYEE + CHILD(REN)
- ☒ EMPLOYEE + SPOUSE
- ☐ EMPLOYEE + FAMILY
- ☐ NO COVERAGE

EMPLOYEE AND DEPENDENT INFORMATION

The following section must be completed if you elected to participate in one or more of the plans above. **Complete the primary care physician section only if you elected to participate in the Point of Service option or the DHMO option.**

Name (Last, First, M.I.)	Date of Birth	Sex	Full-time Student	PCP Number	Existing Patient?	For Office Use Only: Policy Code
Self: DITOMASSO RONALD J	9 14 48	M ☒ F ☐		POS-PCP NUMBER: W100467	Yes ☑ No ☐	
Social Security Number: 028 38 7269				Dental Office Selection	Yes ☐ No ☐	
Spouse/Domestic Partner: DITOMASSO LINDA L	5 11 51	M ☐ F ☒		POS-PCP NUMBER: W100551	Yes ☑ No ☐	
Social Security Number: 024 42 0275				Dental Office Selection	Yes ☐ No ☐	
Child		M ☐ F ☐	Y ☐ N ☐	POS PCP NUMBER	Yes ☐ No ☐	
Social Security Number				Dental Office Selection	Yes ☐	
Child		M ☐ F ☐	Y ☐ N ☐	POS-PCP NUMBER	Yes ☐ No ☐	
Social Security Number				Dental Office Selection	Yes ☐ No ☐	
Child		M ☐ F ☐	Y ☐ N ☐	POS-PCP NUMBER	Yes ☐ No ☐	
Social Security Number				Dental Office Selection	Yes ☐	

RECEIVED FEB 25 2002 Benefits

ELIGIBILITY Candace FEB 26 2002 pc/VST ENTERED BY LESLIE

Is spouse employed? ☒ No ☐ Yes Name of employer _____

Does spouse have other Insurance Coverage? ☒ No ☐ Yes Name of Company _____

Do children have other Insurance Coverage? ☐ No ☐ Yes Name of Company _____

BASIC LIFE AND AD&D

PSC provides all eligible employees Basic Life/Accidental Death and Dismemberment insurance coverage in the amount of [illegible] employee's base annual salary up to $500,000. **PLEASE COMPLETE THE BENEFICIARY SECTION BELOW.** (If a beneficiary is not named below, any proceeds will be paid according to the terms of the policy.)

BENEFICIARY DESIGNATION (BASIC LIFE/AD&D/SUPPLEMENTAL LIFE/VOLUNTARY AD&D)

PRIMARY BENEFICIARY
LINDA L DITOMASSO — NAME
WIFE — RELATIONSHIP

CONTINGENT BENEFICIARY
JAMES & ANTHONY DITOMASSO — NAME
SONS DIVIDED EQUALLY — RELATIONSHIP

SUPPLEMENTAL LIFE INSURANCE MAY BE SUBJECT TO EVIDENCE OF INSURABILITY

CHECK ONE ☒ SMOKER ☐ NON SMOKER (Must not have used tobacco or nicotine products in the last 12 months)

☐ 1 X BASE SALARY ☐ 2 X BASE SALARY ☐ 3 X BASE SALARY ☐ 4 X BASE SALARY ☐ 5 X BASE SALARY ☐ NO COVERAGE

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT

CHECK ONE ☐ EMPLOYEE ONLY PLAN ☐ FAMILY PLAN

☐ 1 X BASE SALARY ☐ 2 X BASE SALARY ☐ 3 X BASE SALARY ☐ 4 X BASE SALARY ☐ 5 X BASE SALARY ☒ NO COVERAGE

SPOUSE AND DEPENDENT CHILD(REN) LIFE - MUST HAVE SUPPLEMENTAL LIFE

SPOUSE COVERAGE (CHECK ONE) Cannot Exceed 50% of Employee Coverage

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000
☐ $80,000 ☐ $90,000 ☐ $100,000 ☐ No Coverage

SPOUSE NAME LINDA L DITOMASSO

SPOUSE BIRTHDATE 5 11 51

SPOUSE SOCIAL SECURITY NUMBER 024 42 0275

☐ SMOKER ☐ NON-SMOKER (Must not have used tobacco or nicotine products in the last 12 months)

Please complete this Evidence of Insurability form for amounts of insurance over $20,000.

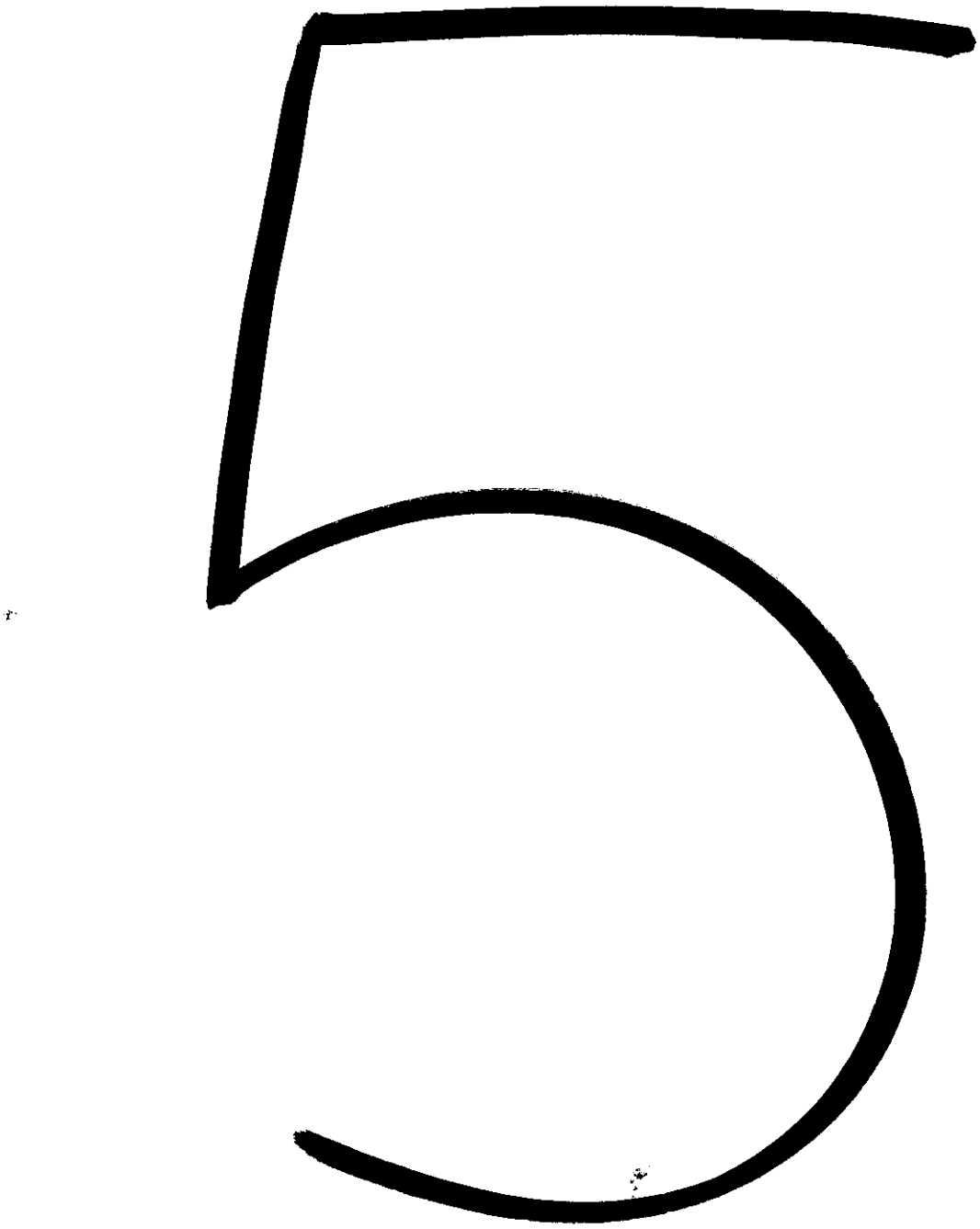
CHILD(REN) COVERAGE (CHECK ONE)
- ☐ $2,000
- ☐ $4,000
- ☐ $6,000
- ☐ $8,000
- ☐ $10,000
- ☒ No Coverage

I understand that misstatements, misrepresentation, or omissions may result in my coverage being void as of its effective date with no benefits payable. I hereby request the group coverage for which I am or may become eligible and authorize deductions from my earnings to serve as payment for any required contributions. My signature below affirms that all information and statements provided on this form are full, complete, and true to the best of my knowledge.

I have selected The Philip Services Health Care Plan for my coverage. I authorize any physician, other health professional, all hospitals and other health care institutions to provide Health Care information concerning health care advice, treatment or supplies provided my dependents and/or myself relating to coverage under this plan.

I have read the explanation of my benefits options. I authorize the above elections and required pre-tax contributions for these elections. I understand that I cannot change or revoke these elections until the next open enrollment period unless there is a change in family status as defined by the Internal Revenue Service. I understand that I have 31 days from my effective date to provide this form to my benefits representative with my election option. If I do not turn in this form within this time period, I understand I will have waived my right to enter plans with pre-tax contributions until the next open enrollment period. I authorize my employer to make the necessary deductions from my wage or salary to pay my premiums for this coverage.

EMPLOYEE SIGNATURE Ronald J. Ditomasso — SHARED SERVICE COPY 2-19-02



[redacted] (OK) (OK) cpn 12/05/02

EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

CHECK ONE: [X] ENROLL [ ] ADD [ ] CANCEL [ ] CHANGE ADDRESS [ ] TRANSFER TO ANOTHER PLAN [ ] NAME CHANGE

NAME (LAST, FIRST, MI): DITOMASSO RONALD J	SOCIAL SECURITY NUMBER: 028-38-7269	EMPLOYEE NUMBER: 301434	
STREET ADDRESS: 128 WORCESTER ROAD, PO BOX 642	CITY: CHARLTON	STATE: MA	ZIP: 01507
HOME PHONE: 508 248 9515	WORK PHONE: 203-333-1652	HIRE DATE: 8 30 00	
EFFECTIVE DATE: 1/1/03	LOCATION: 148	DIVISION: 202	BENEFIT GROUP: HRWK

[ ] SALARIED [X] HOURLY [ ] REHIRE [ ] UNION ____ NAME OF UNION [ ] STATUS CHANGE HRWK

HEALTH PLAN

MEDICAL PLAN OPTIONS (PLEASE CHECK ONE)	TYPE OF COVERAGE (PLEASE CHECK ONE)	DENTAL [ ] PPO [ ] HMO (PLEASE CHECK ONE)	VISION (PLEASE CHECK ONE)
[ ] POINT OF SERVICE PLAN	[ ] EMPLOYEE ONLY	[ ] EMPLOYEE ONLY	[ ] EMPLOYEE ONLY
[X] PPO - PLAN	[ ] EMPLOYEE + CHILD(REN)	[ ] EMPLOYEE + CHILD(REN)	[ ] EMPLOYEE + CHILD(REN)
[ ] OUT OF AREA	[X] EMPLOYEE + SPOUSE	[ ] EMPLOYEE + SPOUSE	[X] EMPLOYEE + SPOUSE
[ ] OTHER ____	[ ] EMPLOYEE + FAMILY	[ ] EMPLOYEE + FAMILY	[ ] EMPLOYEE + FAMILY
[ ] NO COVERAGE	[ ] EMPLOYEE + DOMESTIC PARTNER	[ ] EMPLOYEE + DOMESTIC PARTNER	[ ] EMPLOYEE + DOMESTIC PARTNER
		[X] NO COVERAGE – no chg	[ ] NO COVERAGE

PC/DC cpn

EMPLOYEE AND DEPENDENT INFORMATION

The following section must be completed if you elected to participate in one or more of the plans above. Complete the primary care physician section only if you elected to participate in the Point of Service option or the Dental Office Selection if you selected the Dental HMO option.

Name (Last, First M.I.)	Date of Birth	Sex	Full-time Student	PCP Number	Existing Patient?	420
Self: DITOMASSO RONALD J / Social Security Number: 028 38 7269	9 14 48	M [X] F [ ]		POS-PCP NUMBER: 000000 4084702 / Dental Office Selection	Yes [X] No [ ] / Yes [ ] No [ ]	[X] Enroll [ ] Cancel [ ] Change
Spouse/Domestic Partner: DITOMASSO LINDA L / Social Security Number: 024 42 0275	5 11 51	M [ ] F [X]		POS-PCP NUMBER: 0000177440301 / Dental Office Selection	Yes [X] No [ ] / Yes [ ] No [ ]	[X] Enroll [ ] Cancel [ ] Change
Child / Social Security Number	/ /	M [ ] F [ ]	Y [ ] N [ ]	POS-PCP NUMBER / Dental Office Selection	Yes [ ] No / Yes No	[ ] Enroll [ ] Cancel [ ] Change
Child / Social Security Number	/ /	M [ ] F [ ]	Y [ ] N [ ]	POS-PCP NUMBER / Dental Office Selection	Yes No / Yes No	[ ] Enroll [ ] Cancel [ ] Change
Child / Social Security Number	/ /	M [ ] F [ ]	Y [ ] N [ ]	POS-PCP NUMBER / Dental Office Selection	Yes [ ] No [ ] / Yes [ ] No [ ]	[ ] Enroll [ ] Cancel [ ] Change

ELIGIBILITY DEC 0 4 2002 ENTERED BY LESLIE

Is spouse employed? [ ] No [X] Yes Name of employer STAT-CARE PHARMACY

Does spouse have other Insurance Coverage? [X] No [ ] Yes Name of Company ____

Do children have other Insurance Coverage? [ ] No [ ] Yes Name of Company ____

RECEIVED NOV 19 2002

BASIC LIFE AND AD&D

PSC provides all eligible employees Basic Life/Accidental Death and Dismemberment insurance coverage in the amount of the employee's base annual salary up to $500,000. PLEASE COMPLETE THE BENEFICIARY SECTION BELOW. (If a beneficiary is not named below, any proceeds will be paid according to the terms of the policy.)

The written consent of your spouse is required if you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA OR WI and you name someone other than your spouse as beneficiary.

BENEFICIARY DESIGNATION (BASIC LIFE/AD&D/SUPPLEMENTAL LIFE/VOLUNTARY AD&D)

PRIMARY BENEFICIARY
NAME: LINDA L DITOMASSO — RELATIONSHIP: WIFE

CONTINGENT BENEFICIARY
NAME: JAMES + ANTHONY DITOMASSO — RELATIONSHIP: SONS — DIVIDED EQUALLY

SUPPLEMENTAL LIFE INSURANCE MAY BE SUBJECT TO EVIDENCE OF INSURABILITY

CHECK ONE [X] SMOKER [ ] NON SMOKER (Must not have used tobacco or nicotine products in the last 12 months) EOI required for amounts > $250,000

[X] 1 X BASE SALARY [ ] 2 X BASE SALARY [ ] 3 X BASE SALARY [ ] 4 X BASE SALARY [ ] 5 X BASE SALARY [ ] NO COVERAGE

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT

CHECK ONE [ ] EMPLOYEE ONLY PLAN [ ] FAMILY PLAN

[ ] 1 X BASE SALARY [ ] 2 X BASE SALARY [ ] 3 X BASE SALARY [ ] 4 X BASE SALARY [ ] 5 X BASE SALARY [X] NO COVERAGE

SPOUSE AND DEPENDENT CHILD(REN) LIFE - MUST HAVE SUPPLEMENTAL LIFE TO ENROLL IN THIS COVERAGE

SPOUSE COVERAGE (CHECK ONE) Cannot Exceed 50% of Employee Coverage

[X] $10,000 [ ] $20,000 [ ] $30,000 [ ] $40,000 [ ] $50,000 [ ] $60,000 [ ] $70,000
[ ] $80,000 [ ] $90,000 [ ] $100,000 [ ] No Coverage

SPOUSE NAME LINDA L DITOMASSO
SPOUSE BIRTHDATE 5 / 1 / 51
SPOUSE SOCIAL SECURITY NUMBER 024 42 0275
[X] SMOKER [ ] NON-SMOKER (Must not have used tobacco or nicotine products in the last 12 months)
Please complete Evidence of Insurability form for amounts of insurance over $20,000.

CHILD(REN) COVERAGE (CHECK ONE)
[ ] $2,000
[ ] $4,000
[ ] $6,000
[ ] $8,000
[ ] $10,000
[X] No Coverage

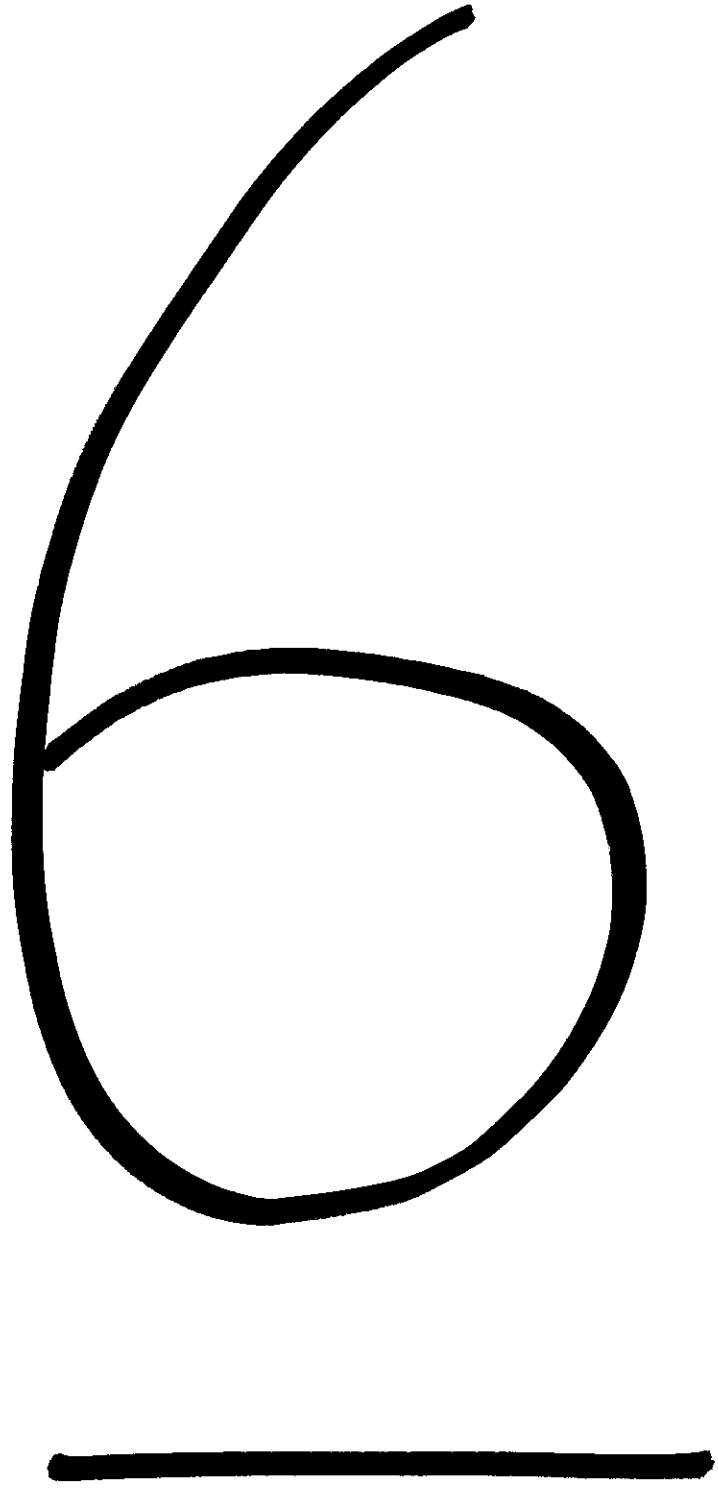
I understand that misstatements, misrepresentation, or omissions may result in my coverage being void as of its effective date with no benefits payable. I hereby request the group coverage for which I am or may become eligible and authorize deductions from my earnings to serve as payment for any required contributions. My signature below affirms that all information and statements provided on this form are full, complete, and true to the best of my knowledge.

I have selected The Philip Services Health Care Plan for my coverage. I authorize any physician, other health professional, all hospitals and other health care institutions to provide Health Care information concerning health care advice, treatment or supplies provided my dependents and/or myself relating to coverage under this plan.

I have read the explanation of my benefits options. I authorize the above elections and required pre-tax contributions for these elections. I understand that I cannot change or revoke these elections until the next open enrollment period unless there is a change in family status as defined by the Internal Revenue Service. I understand that I have 31 days from my effective date to provide this form to my benefits representative with my election option. If I do not turn in this form within this time period, I understand I will have waived my right to enter plans with pre-tax contributions until the next open enrollment period. I authorize my employer to make the necessary deductions from my wage or salary to pay my premiums for this coverage.

EMPLOYEE SIGNATURE Ronald J. Ditomasso — 11/13/02 DATE

SHARED SERVICE COPY



(INSTRUCTIONS ON REVERSE SIDE)
FOR USE BY PHYSICIANS AND MEDICAL EXAMINERS

The Commonwealth of Massachusetts

STANDARD CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

130
REGISTERED NUMBER

STATE USE ONLY

STATE USE ONLY
4c Hosp
5 Type
6 Hisp | Race
15 Resic
15 Out-State
2nd Disp
31-32 Autop
34 Manner
35c Work Inj
35f Place
36-37 Cert
40a Pron

DECEDENT

DECEDENT - NAME FIRST (1)	MIDDLE	LAST	SEX (2)	DATE OF DEATH (Mo., Day, Yr.) (3)
Ronald	J.	Ditomasso	Male	December 26,200

PLACE OF DEATH (City/Town) (4a)	COUNTY OF DEATH (4b)	HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number) (4c)
Charlton	Worcester	128 Worcester Rd.

PLACE OF DEATH (Check only one): HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA (5) — OTHER: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

SOCIAL SECURITY NUMBER (6): 028-38-7269

IF US WAR VETERAN SPECIFY WAR (7): Vietnam

WAS DECEDENT OF HISPANIC ORIGIN? (If yes, Specify Puerto Rican, Dominican, Cuban, etc.) (8a) ☒ NO ☐ YES — Specify:

RACE (e.g. White, Black, American Indian, etc.) (Specify) (8b): White

DECEDENT'S EDUCATION (Highest Grade Completed) Elementary Sec (0-12) (9): 12 | College (1-4, 5+)

AGE - Last Birthday (Yrs.) (10a)	UNDER 1 YEAR MOS. (b)	DAYS	UNDER 1 DAY HOURS (c)	MINS	DATE OF BIRTH (Mo., Day, Yr.) (10d)	BIRTHPLACE (City and State or Foreign Country) (11)
55					Sept.4,1948	Southbridge,Massachusetts

MARRIED, NEVER MARRIED WIDOWED OR DIVORCED (12)	LAST SPOUSE (If wife, give maiden name) (13)	USUAL OCCUPATION (Prior - If Retired) (14a)	KIND OF BUSINESS OR INDUSTRY (14b)
Married	Linda L.Reinhold	Supervisor	Environmental Co.

RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY (15a): 128 Worcester Rd,Charlton,Worcester,Massachusetts — ZIP CODE (15b): 01507

FATHER - FULL NAME (16)	STATE OF BIRTH (If not in US, name country) (17)	MOTHER - NAME (GIVEN) (MAIDEN) (18)	STATE OF BIRTH (If not in the US, name country) (19)
Guido A.Ditomasso	MA.	Laurette J.Benoit	MA.

INFORMANT

INFORMANT'S NAME (20)	MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE (21)	RELATIONSHIP (22)
Linda L.Ditomasso	128 Worcester Rd,Charlton,MA. 01507	Wife

DISPOSITION

METHOD OF IMMEDIATE DISPOSITION (23)	FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE (24)	LICENSE # (25)
☒ BURIAL ☐ CREMATION ☐ ENTOMBMENT ☐ REMOVAL FROM STATE ☐ DONATION ☐ OTH. SPEC.	Robert J.Miller	5708

PLACE OF DISPOSITION (Name of Cemetery, Crematory or other) (26a)	LOCATION (City/Town, State) (26b)
West Ridge Cemetery	Charlton,Massachusetts

DATE OF DISPOSITION (Mo., Day, Yr.) (27)	NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE (28a/b)
December 29,2003	Robert J.Miller,Inc,175 Old Worcester Rd,Charlto MA. 01507

CERTIFIER

29 PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d) PRINT OR TYPE LEGIBLY.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Lung CANCER	months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF)	
	c. DUE TO (OR AS A CONSEQUENCE OF)	
	d. DUE TO (OR AS A CONSEQUENCE OF)	

PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I. (30)

WAS AUTOPSY PERFORMED? (Yes or No) (31)	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) (32)
NO	

MED. EXAM. NOTIFIED? (Yes or No) (33)	MANNER OF DEATH (34)	DATE OF INJURY (Mo., Day, Yr.) (35a)	TIME OF INJURY (35b)	INJURY AT WORK (Yes or No) (35c)
NO	☒ NATURAL ☐ HOMICIDE ☐ COULD NOT BE DETERMINED ☐ ACCIDENT ☐ SUICIDE ☐ PENDING INVESTIGATION	0	M	

DESCRIBE HOW INJURY OCCURRED (35d)	PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.,) Specify (35e)	LOCATION (No. & St., City/Town, State) (35f)

To be Completed by CERTIFYING PHYSICIAN ONLY

36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title) David Mero

DATE SIGNED (Mo., Day, Yr.) (36b)	HOUR OF DEATH (36c)
December 26,2003	8:20 A M

NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER (36d)

To be Completed by MEDICAL EXAMINER ONLY

37a On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) stated. (Signature and Title)

DATE SIGNED (Mo., Day, Yr.) (37b)	HOUR OF DEATH (37c)
	M

PRONOUNCED DEAD (Mo., Day, Yr.) (37d)	PRONOUNCED DEAD (Hr) (37e)
	M

NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print) (38): DAVID SHEPRO, 85 Prescott Street, Worcester — LICENSE NO. OF CERTIFIER (39): 55686

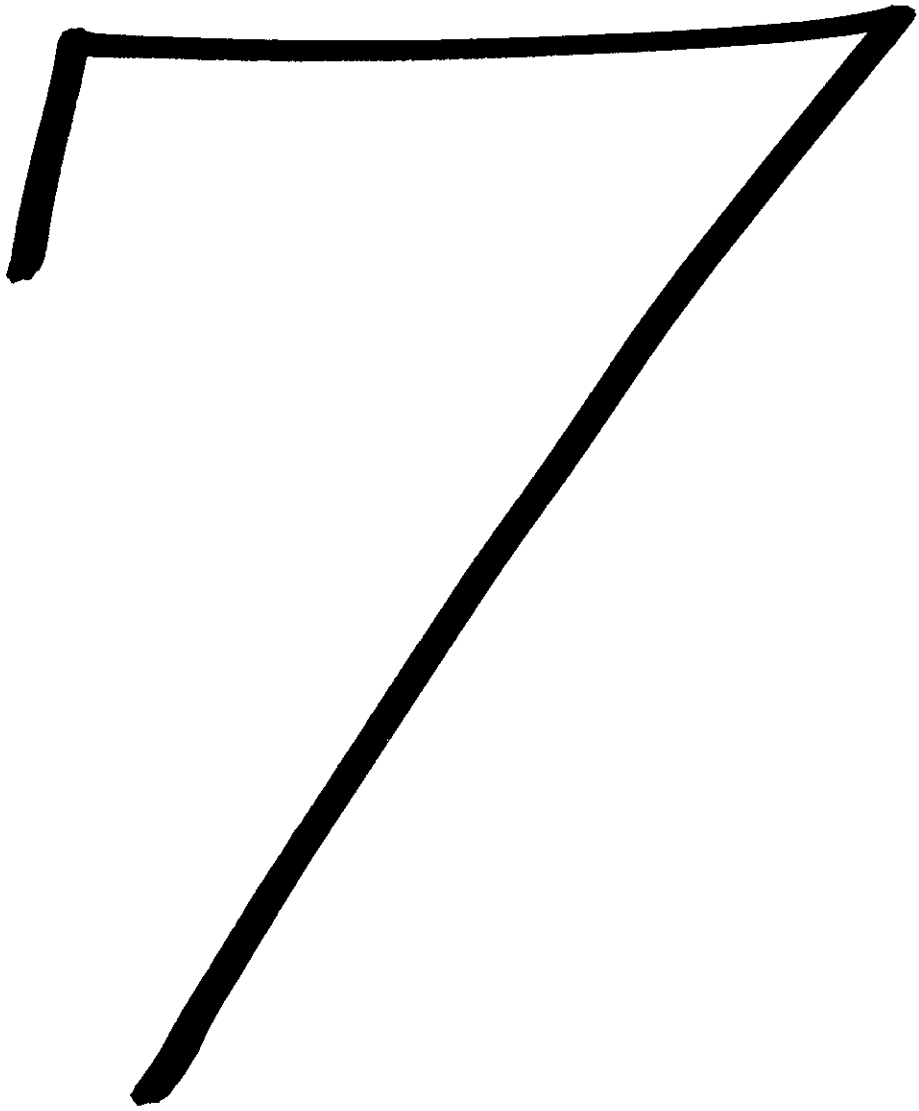
WAS THERE A PRONOUNCEMENT FORM? (Yes or No) (40a)	IF YES, DATE PRONOUNCED (40b)	IF YES, TIME PRONOUNCED (40c)	40d NAME OF PRONOUNCER	TITLE
Yes	Dec.26,2003	8:20 A M	Rebecca Postma	☒ R.N. ☐ P.A.

DATE BURIAL PERMIT ISSUED (41)	RECEIVED IN THE CITY/TOWN OF (42)	DATE OF RECORD (43)
Dec,29,2003	CHARLTON	Dec 29, 2003
SIGNATURE-BD. OF HEALTH AGENT: Susan Nichols AM	CLERK'S SIGNATURE: Susan J Nichols	

Pronouncement of Death Form (R-302) on File: ☒

PERMANENT BLACK INK ONLY

R-301-01



Continental Assurance Company

CNA

For All the Commitments You Make®

Group Life / Accidental Death & Dismemberment Insurance Proof Of Death Form

LIFE CLAIMS TEAM

8312054

GROUP BENEFI

FEB 11 2004

FEB 11 2004

2004 FEB 11 AM 8:00

MAITLAND

For Death of Employee Only – Statement of Employer and Beneficiary

Name & Address of Deceased Employee **Ronald Ditomasso** 128 Worcester Charlton, MA 01507		Group Policy Account Number **83120543** Employee Class: (Certificate #) **Salaried** / Location **Hou**
Name & Address of Employer **Philip Services Corp.** 5151 San Felipe Ste. 1600 Houston, TX 77056		Amount of Insurance: $ **35,000 Basic Life** **$35,000 Supp Life** Is Employee Insurance In-Force? ☒ Yes ☐ No
Date of Death (Month/Day/Year) 12/26/2003	Date of Birth (Month/Day/Year) **09/04/1948**	If Yes, Effective Date: **01/01/2001** If No, Date of Cancellation:
Date Last Reported for Work **08/22/2003**	Duration of Employment From: **05/30/2000** To: 12/26/2003	Occupation of Deceased at Death: **Driver** Annual Salary: $ 34,112.00
Name & Address of Beneficiary **Linda Ditomasso** **P.O. Box 642** **Charlton, MA 01507**		Relationship (to Insured) **Wife** / Date of Birth **05/01/1951**

FEDERAL LAW — Federal Law requires us to give you this information. We may have to withhold and send to the IRS 31 % of certain reportable payments you may be entitled to. We will not have to withhold this amount if we have your correct Social Security Number, and you state that you have not been notified that you are subject to an IRS Back-up Withholding Order on Interest and Dividends.

RECEIVED JAN 16 2004

** By signing below:

(1) **I Hereby Certify and Agree** that I have not been notified by the Internal Revenue Service (IRS) that I am subject to a Back-up Withholding Order on Interest and Dividends. (If you have been so notified, cross out this statement "(1)". Provide your initials and today's date next to the cross out marks).

(2) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE contained on the reverse side of (or attached to) this claim form.

(3) **I Understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if Continental Assurance Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

(4) X **I Authorize** the Continental Assurance Company to pay the death proceeds into an Assured Access Account (retained asset account). If an Assured Access Account is not an available form of payment for the group referenced above, I authorize the Continental Assurance Company to pay the proceeds to me in a lump sum payment. This will be in lieu of any alternate mode of settlement available under the policy. **(If you do not wish to have the proceeds paid into an Assured Access Account, you may cross out this statement "(4)", and attach your written request for some other method of payment available under the policy.)**

(5) **I hereby authorize** Continental Assurance Company to use any personal or privledged information contained on this form to settle my claim for benefits. The information that I provide may be used by Continental Assurance Company only during the duration of my claim.

****Beneficiary Signature** X Linda L. Ditomasso	Social Security Number of Beneficiary 024 42 0275
Send Check To: LINDA L DITOMASSO PO BOX 642 CHARLTON MA 01507	Signature of Employer Representative X Telephone Number (Include Area Code) 713-625-7017 Date 11/30/04

L438-010-L (Revised 8/00) **Mail to: CNA Group Benefits, P. O. Box 946790, Maitland, FL. 32794-6790**

33639

****IMPORTANT NOTICE****

Residents of all states EXCEPT FL, NJ, AZ: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

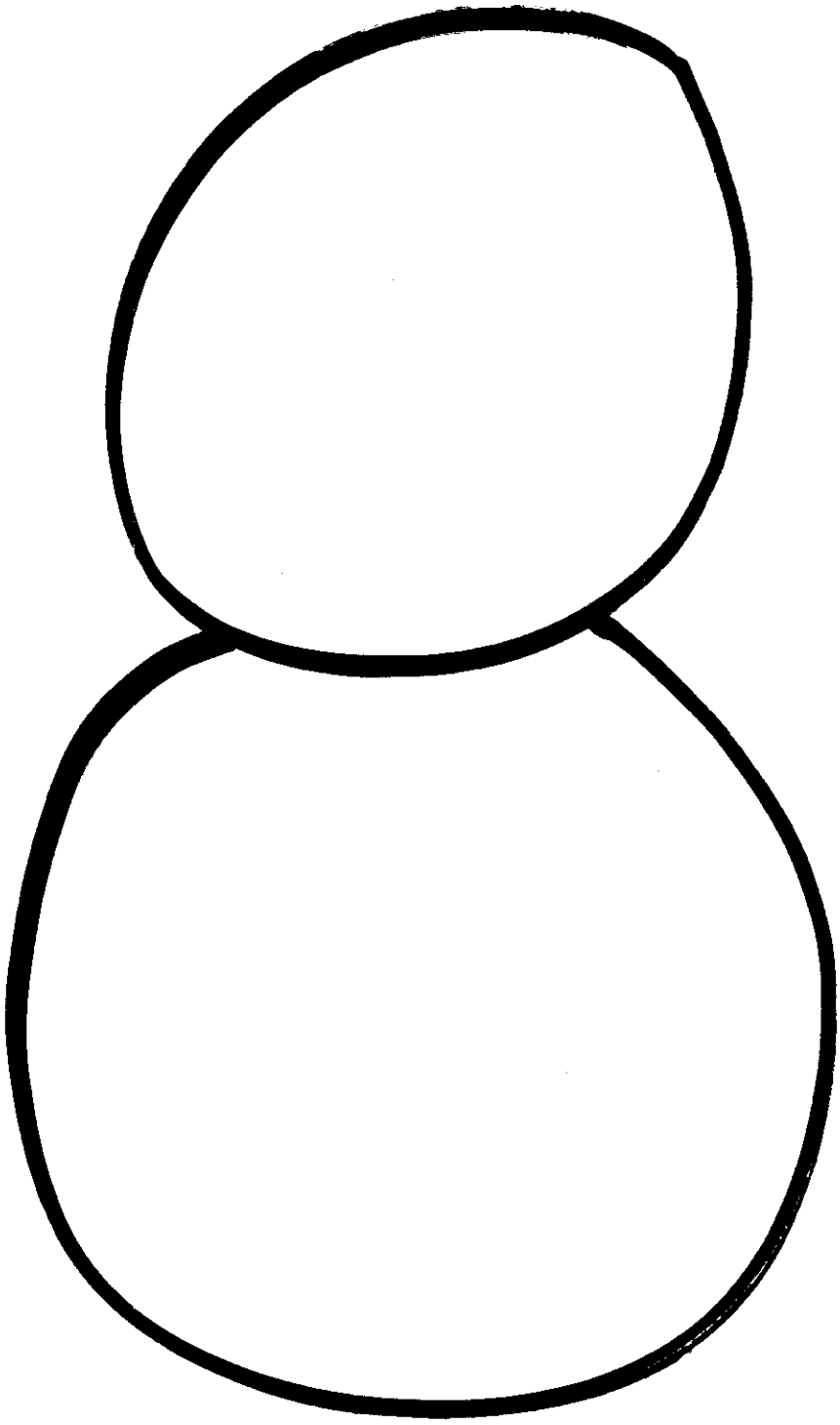
FLORIDA RESIDENTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NJ RESIDENTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

ARIZONA RESIDENTS: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

INSTRUCTIONS FOR COMPLETING PROOF OF DEATH FORM

- The upper portion of this form is to be completed by the Official Representative of the Employer. A certified copy of the Death Certificate must be attached to this form.
- In any case where a claim for accidental death is being made, in addition to the proof of death form, furnishing a newspaper account, police report, or coroner's verdict can facilitate consideration of such claim.
- If the claim proceeds are payable to the estate or executors or administrators of the Insured, statement must be made by an executor or administrator. A certificate of such person's appointment and qualification must be attached to this form.
- If the claim proceeds are payable to a minor, statement must be made by a guardian. An official certificate of the guardian's appointment and qualification must be attached to this form.



Group Operations
PO Box 946790 Maitland, FL 32794-6790

Lou Davia, CPCU
Life Specialist
Telephone *407-919-6250*
800-303-9744 Extension 6250
Facsimile *407-919-6329*
Internet *lillie.davia@cna.com*

February 16, 2004

Mrs. Linda L. Ditomasso
P.O. Box 642
Charlton, MA 01507

Insured: Ronald Ditomasso, deceased
Claim Number: 4575450
Policy Number: 83120541
Underwritten by Continental Assurance Company
Services provided by CNA Group Life Assurance Company

Dear Mrs. Ditomasso:

We are sorry to hear of the death of your husband, Ronald Ditomasso, and wish to offer our condolences to your family.

The Basic Life Insurance benefit payable under the above-named policy has been approved in the amount of $35,000.00. A check has been issued and forwarded under separate cover.

In addition to processing your claim, CNA offers a program to assist you in various areas during your time of grief. The program offered is called Beneficiary Assist and provides several services such as grief counseling, legal counseling and financial planning. Please take a moment and read the pamphlet enclosed with this letter.

We have carefully reviewed all relevant documents pertaining to the claim for Group Term Supplemental Life benefits and have determined that you are not eligible to receive proceeds under the Supplemental Life portion of the policy. Please allow us to explain.

According to the information provided to us, Mr. Ditomasso was hired on May 30, 2000 which was prior to January 1, 2001, the effective date of our policy for Philip Services Corporation. Our review of the enrollment forms indicates that he first elected Supplemental Life coverage on December 10, 2001. This would have been for an effective date of coverage of January 1, 2002. There is no indication that he elected Supplemental Life coverage prior to this date. We direct your attention to the "**Eligibility and Enrollment**" provision of Philip Services Corporation's Group Term Life insurance policy which states:

What happens during Your initial enrollment period?

"When You are first eligible to enroll, You will automatically be enrolled for Non-Contributory Life Insurance and any other Non-Contributory coverage. You may refuse such coverage. The refusal must be in writing on a form provided by Us. If You later apply for coverage, You will be considered a Late Enrollee".

What is required to become insured?

"To become insured You must:

1) be an Eligible Person;
2) complete the Waiting Period, if any;
3) complete a group insurance enrollment form acceptable to Us;
4) provide any required Proof of Insurability; and
5) Agree to pay any premium.

We now direct you to the "**Effective Dates**" provision of the policy:

When does Your insurance start?

"If You enroll within 31 days after first becoming eligible to enroll for coverage, Your insurance up to the Guaranteed Issue Amount will take effect on the later of:

1) the date You enroll; or
2) the date You satisfy the Waiting Period, if any. . . . . .

No coverage will go into effect until You have satisfied the Waiting Period. If you are a Late Enrollee, Your insurance will take effect on the first of the month that falls on or next follows the date We approve Your Proof of Insurability."

Please refer to the "**Definitions**" section of the policy which states as follows:

"**Late Enrollee** means You enroll for coverage more than 31 days after You are first eligible to enroll. . . . . ."

As indicated previously, the effective date of our coverage with Philip Services was January 1, 2001; however, our records indicate that the enrollment period was extended to April 1, 2001. Based on this, Mr. Ditomasso would have had 31 days from April 1, 2001 to elect his Life insurance coverages. Unfortunately, there is no indication that he elected Supplemental Life coverage until his enrollment form dated December 10, 2001.

Based on the above, we must respectfully deny benefits under the Supplemental Life portion of the policy. We are sorry that our decision could not have been more favorable, but we must abide by the policy provisions. Any premiums paid for the coverage will be refunded.

If you disagree with our decision, you have the right to appeal. This appeal is afforded in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended, to the extent it is applicable to your claim..

If you have additional medical information not mentioned above or wish us to reconsider our decision, you should submit your formal request for reconsideration in writing to my attention within 180 days of the date of this letter. Your appeal should be addressed to:

Attn: Lou Davia
CNA Group Operations
Life/AD&D/Accident Claims
P.O. Box 946790
Maitland, Florida 32794-6790

Include your claim number and policy number on any correspondence.

We will reconsider our decision at the time we receive the additional information you submit. If this information does not alter our decision, you will be informed of this and your claim will then be submitted for a formal appeal review. A ruling will be issued within 45 days of receipt of your request for reconsideration; however, you will be notified within the first 45 days if this review will require an extension of time to reach a decision. This decision will be in writing and mailed directly to you or your representative. To the extent your claim is governed by ERISA, you have the right to bring a civil action under § 502(a) of ERISA following an adverse decision on appeal.

Appeals received later than 180 days may not be considered.

Sincerely,

Lou Davia
Life Specialist

cc: Philip Services Corporation
Attn: Antoine Carter, HR Manager
5151 San Felipe, Suite 1600
Houston, TX 77056

05-40057 FDS

JS 44 (Rev. 11/04)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

I. (a) PLAINTIFFS

Linda Ditomasso

(b) County of Residence of First Listed Plaintiff Worcester
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorney's (Firm Name, Address, and Telephone Number)

William J. Ritter, Esquire, Natania M. Davis, Esquire; Pojani Hurley Ritter & Salvidio, LLP, 446 Main Street, Worcester, MA 01608; 508.798.2480

DEFENDANTS

Philip Services Corporation, PSC Group Life Plan and Continental Assurance Company

County of Residence of First Listed Defendant Cumberland, Maine
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT
- ☒ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury

PERSONAL INJURY
- ☐ 362 Personal Injury - Med. Malpractice
- ☐ 365 Personal Injury - Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 444 Welfare
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 440 Other Civil Rights

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence

Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition

FORFEITURE/PENALTY
- ☐ 610 Agriculture
- ☐ 620 Other Food & Drug
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 630 Liquor Laws
- ☐ 640 R.R. & Truck
- ☐ 650 Airline Regs.
- ☐ 660 Occupational Safety/Health
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 730 Labor/Mgmt.Reporting & Disclosure Act
- ☐ 740 Railway Labor Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Empl. Ret. Inc. Security Act

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 810 Selective Service
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 875 Customer Challenge 12 USC 3410
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 892 Economic Stabilization Act
- ☐ 893 Environmental Matters
- ☐ 894 Energy Allocation Act
- ☐ 895 Freedom of Information Act
- ☐ 900Appeal of Fee Determination Under Equal Access to Justice
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN (Place an "X" in One Box Only)

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from another district (specify) ☐ 6 Multidistrict Litigation ☐ 7 Appeal to District Judge from Magistrate Judgment

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing **(Do not cite jurisdictional statutes unless diversity)**:
29 U.S.C. Section 1132(a)(1)(B)

Brief description of cause:
Death benefits under life insurance policy.

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
03/24/2005

SIGNATURE OF ATTORNEY OF RECORD
William J. Ritter

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

05-40057 FDS

1. Title of case (name of first party on each side only) Ditomasso vs. Philip Services Corporation

2. Category in which the case belongs based upon the numbered nature of suit code listed on the civil cover sheet. (See local rule 40.1(a)(1)).

☐	I.	160, 410, 470, R.23, REGARDLESS OF NATURE OF SUIT.	
☐	II.	195, 196, 368, 400, 440, 441-446, 540, 550, 555, 625, 710, 720, 730, 740, 790, 791, 820*, 830*, 840*, 850, 890, 892-894, 895, 950.	*Also complete AO 120 or AO 121 for patent, trademark or copyright cases
☑	III.	110, 120, 130, 140, 151, 190, 210, 230, 240, 245, 290, 310, 315, 320, 330, 340, 345, 350, 355, 360, 362, 365, 370, 371, 380, 385, 450, 891.	
☐	IV.	220, 422, 423, 430, 460, 480, 490, 610, 620, 630, 640, 650, 660, 690, 810, 861-865, 870, 871, 875, 900.	
☐	V.	150, 152, 153.	

3. Title and number, if any, of related cases. (See local rule 40.1(g)). If more than one prior related case has been filed in this district please indicate the title and number of the first filed case in this court.

None.

4. Has a prior action between the same parties and based on the same claim ever been filed in this court?

YES ☐ NO ☑

5. Does the complaint in this case question the constitutionality of an act of congress affecting the public interest? (See 28 USC §2403)

YES ☐ NO ☑

If so, is the U.S.A. or an officer, agent or employee of the U.S. a party?

YES ☐ NO ☐

6. Is this case required to be heard and determined by a district court of three judges pursuant to title 28 USC §2284?

YES ☐ NO ☑

7. Do all of the parties in this action, excluding governmental agencies of the united states and the Commonwealth of Massachusetts ("governmental agencies"), residing in Massachusetts reside in the same division? - (See Local Rule 40.1(d)).

YES ☐ NO ☐

A. If yes, in which division do all of the non-governmental parties reside?

Eastern Division ☐ Central Division ☐ Western Division ☐

B. If no, in which division do the majority of the plaintiffs or the only parties, excluding governmental agencies, residing in Massachusetts reside?

Eastern Division ☐ Central Division ☑ Western Division ☐

8. If filing a Notice of Removal - are there any motions pending in the state court requiring the attention of this Court? (If yes, submit a separate sheet identifying the motions)

YES ☐ NO ☐

(PLEASE TYPE OR PRINT)

ATTORNEY'S NAME William J. Ritter, Esquire; Natania M. Davis, Esquire

ADDRESS Pojani Hurley Ritter & Salvidio, LLP, 446 Main Street, Worcester, MA 01608

TELEPHONE NO. 508.798.2480

(CategoryForm.wpd - 2/15/05)